

2011

The United State of Birth: A Feminist Crique

Amanda Hardy
Iowa State University

Follow this and additional works at: <https://lib.dr.iastate.edu/etd>



Part of the [Family, Life Course, and Society Commons](#)

Recommended Citation

Hardy, Amanda, "The United State of Birth: A Feminist Crique" (2011). *Graduate Theses and Dissertations*. 10252.
<https://lib.dr.iastate.edu/etd/10252>

This Dissertation is brought to you for free and open access by the Iowa State University Capstones, Theses and Dissertations at Iowa State University Digital Repository. It has been accepted for inclusion in Graduate Theses and Dissertations by an authorized administrator of Iowa State University Digital Repository. For more information, please contact digirep@iastate.edu.

The united state of birth: A feminist critique

by

Amanda Hardy

A dissertation submitted to the graduate faculty
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

Major: Human Development and Family Studies

Program of Study Committee:
Sedahlia Jasper Crase, Co-major Professor
Cathy Hockaday, Co-major Professor
Susan Maude
Dianne Draper
Christine Cook

Iowa State University

Ames, Iowa

2011

DEDICATION

It is with great love, sincere respect and the deepest appreciation that I dedicate this project to my mother.

If ever a day goes by that I do not say I love you, know that I always do.

TABLE OF CONTENTS

DEDICATION	ii
LIST OF FIGURES	vii
LIST OF TABLES	viii
ACKNOWLEDGEMENTS	ix
ABSTRACT	xii
GLOSSARY	xiii
AUTHOR'S STATEMENT	xiv
BACKGROUND INFORMATION	xvii
CHAPTER 1	1
Theoretical Perspective	4
Goals of Feminist Research	4
Assumptions of Feminist Research	6
CHAPTER 2	7
A Brief History of Childbirth in America	8
Birth in Colonial America	11
Maternity Hospitals	16
The Move From Home to Hospital	17
The Iatrogenic Condition of Birth	21
A Propaganda Campaign	24
The Birth of Surgical Birth	29
The Birth of Twilight Sleep	31
The Pregnancy Factory	33
The Rebirth of Nature	34
The Future of Birth	40

Modern Day Birth	43
Birth by the Numbers	43
Physiological Childbirth	46
The Effects of Childbirth	47
The Woman – The Mother	47
The Child	55
CHAPTER 3	60
Methodology and Theoretical Perspective	60
Participants	61
Procedures	65
Quality and Rigor	72
Challenges and Ethical Considerations	76
Presentation of Findings	78
CHAPTER 4	81
Part I	82
Eleanor’s Story: The Bumper Sticker	82
Emma’s Story: A Perfectly Healthy Little Girl	88
Isabella’s Story: The Next Appointment	93
Judy’s Story: A Real Mom	99
Layla’s Story: The Power of a Positive Friend	103
Molly’s Story: My Triathlon	107
Cassandra’s Story: The First Moments	112
Lily’s Story: Crunchy Granola	115
Dr. Steven Reid: My House and My Horse	119
Jessica’s Story: This is Top Secret	125
Paige’s Story: One Woman at a Time	136
Part II	141
Theme 1: I’m a Person, Not a Chart	142
Theme 2: Risk and Liability	145
Theme 3: It Takes a Village	148
Theme 4: Who Is In Charge Here? Power, Control, and Informed Consent	151
Theme 5: Asking Questions and Self-Advocating	154
Theme 6: Fear	158

Theme 7: The Power of Perception	161
Theme 8: Health Reports	168
The Baby: Un-finding	172
Summary of Part II	174
Results from Cohort Group	176
CHAPTER 5	179
Future Directions	181
Limitations	182
Final Thoughts	183
REFERENCES	186
APPENDIX A: RECRUITMENT FLYER	202
APPENDIX B: PROFESSIONAL RECRUITMENT LETTER	203
APPENDIX C: RESEARCH SUMMARY SHEET	204
APPENDIX D: INTERVIEW SUMMARY SHEET	206
APPENDIX E: INTERVIEW QUESTIONS	207
APPENDIX F: TRANSCRIPTION NOTES FORM	209
APPENDIX G: EXAMPLE OF USE OF TRANSCRIPTION NOTES FORM	210
APPENDIX H: EXCERPTS FROM TRANSCRIPTS	211
APPENDIX I: CODEBOOK	255
APPENDIX J: THIRTY-SEVEN INITIAL BROAD CATEGORIES	267
APPENDIX K: BRIEF DESCRIPTION OF EACH INITIAL CATEGORY	268

APPENDIX L: TALLY SHEET	279
APPENDIX M: TABLE REPRESENTING HOW CATEGORIES COMBINED	281
APPENDIX N: PRELIMINARY RESULTS DOCUMENT	282
APPENDIX O: INSTRUCTIONS AND FEEDBACK FORM FOR REVIEWERS	290
APPENDIX P: EMAIL TO PARTICIPANTS	292
APPENDIX Q: SELECTED EXCERPTS	293
APPENDIX R: APPROVED HUMAN SUBJECTS DOCUMENTS	296

List of Figures

Figure 1: Timeline Representing Pivotal Moments in U.S. Childbirth History.....	10
Figure 2: Representation of the Circular Logic of the Use of Instruments in Birth.....	15
Figure 3: Visual Representation of Data Analysis.....	68
Figure 4: Matrix Reflecting Original Research Questions with Corresponding Themes.....	174
Figure 5: Graphic Representation of Themes.....	176
Figure 6: 1970s Cohort Graphic.....	177
Figure 7: 1980s Cohort Graphic.....	178
Figure 8: 1990s Cohort Graphic.....	178

List of Tables

Table 1: All Women Participants with Information Related to First Birth.....	63
Table 2: Professional Participants.....	65

ACKNOWLEDGEMENTS

I have to, first and foremost, offer praise and gratitude to God. I have often questioned the various puzzle pieces of my life – my journey – and how they all fit together, but in the past years I have felt a sincere sense of clarity and purpose like never before. I am truly grateful for God’s provision and love for me and I trust that his plans are indeed great.

I need to thank my family for the unwavering support and encouragement throughout this entire experience. To my husband, Keiser, who tolerated all the highs and lows with love, grace, and patience – thank you. To my mother, father, and sister who have always been my biggest cheerleaders. The three of you have also been the best childcare providers any mother could ever dream of, and as such, have offered my son some unbelievable and amazing childhood moments. To Jack, my son, because of our experience together during your birth my life has been changed. Those experiences were deeply empowering for me and I will treasure them for the rest of my life. However, Jack, I thank you most of all simply for being you -- thank you for being the amazing, wonderful, kind, patient, understanding, and sweet little boy that you are. I am so blessed by you!

Sedahlia, I am so honored to call myself one of your students. Most of all, to know that I had the distinguished honor to be one of your post-retirement students is very special and for that I am forever grateful. I have struggled over recent days to articulate all the things you have “taught” me over the past few years. It turns out it is hard to measure such things! Being randomly assigned to you as a new student in the department was so very serendipitous and I am so appreciative of that fortunate accident. I cannot imagine my

experience at Iowa State, this research project, or my life without your involvement. Thank you for all that you have been and for all that I am sure you will continue to be.

Cathy I have thoroughly enjoyed working with you on this research and having you be a part of my life. I have enjoyed getting to know you and the way in which you have guided and supported me during this entire process. I am grateful for your honesty and your humor and the way in which they both have offered me so much personally and professionally. I look forward to continued collaboration with you in the future. I am confident any chance I get to work with you will be fun-filled!

Sedahlia and Cathy you have truly mothered me – nurtured and lovingly supported me – through this entire doctoral process. Thank you, from the bottom of my heart!

To the members of my committee, Dianne Draper, Chris Cook, and Susan Maude I also feel honored and grateful to each of you for your various roles in my life over the past few years and specifically for your willingness to serve on my committee. I have had amazing opportunities to learn from each of you in the classroom, and in one capacity or another each served as a mentor to me in various contexts. For both of these roles I want to say I appreciate you and the way you have impacted my life and my academic experience – thank you.

To my professional and academic colleagues: specifically, thanks to the members of my “nerd group,” Aryn, Jason, Nancy, and Jen for being by my side (and often holding my hand) throughout this process. Your wisdom, guidance, and friendship have made a tremendous impact on my life and on this project – thank you. Haley and Tara, you are both beloved friends and I am so very grateful to both of you for sharing your gifts, talents, and

lives with me. You have each been wonderfully supportive of me, and this project, and I am so blessed to have had you both with me on this journey. More so, I am grateful for the roles you have played in my life, and the life of this project; I anticipate, with much joy, opportunities for future collaboration with you.

Last, but most certainly not least, I offer my sincerest appreciation and gratitude to the women and men who shared their deeply personal life experiences with me as participants in this study. You have each taught me so much! Without your kindness and willingness to participate, this project would be nothing. My experiences with each of you have both shaped and changed this research project in ways I could have never imagined, but not insignificantly they have also shaped and changed me personally. It is the latter that will endure, and for this I am truly grateful. Thank you for sharing your stories with me, thank you for being part of this study, and most of all thank you for being a part of my life. You are unforgettable to me; forever you will remain in a place of gratitude in my heart.

ABSTRACT

Having a baby is a significant and life changing event for women and their families. History and culture have a tremendous impact on our modern day lives in many ways, several of which we are often unaware. The purpose of this study was to explore how women feel about their childbirth experiences and most significantly, how do they feel about themselves following their journey through the maternity culture in America. This study explored the hegemonic modern maternity culture and the ways in which this culture impacts the women who experience it. Eight women and four professional maternity care providers, as well as 5 women representing different decade cohorts, were interviewed. The voices of participants were privileged through the process, including analysis and presentation of findings. Specifically areas in which women reported being silenced or disenfranchised were highlighted. Findings were reported in two parts; first a narrative [re]telling of each of the twelve participant's stories was shared, followed by thematic representations of the data gleaned from participant experiences. Eight themes were constructed: (a) I'm a person, not a chart, (b) Risk and liability, (c) It takes a village (d) Who is in charge here? Power, control, and informed consent, (e) Asking questions and self-advocating, (g) Fear, (f) Power of perception and (h) Health reports. Findings are consistent with previous studies on maternity experience and also provide new evidence in understanding the deeply personal life-changing experiences of childbirth.

GLOSSARY¹

Birth Plan	A written document, created by a woman, indicating her desires for her birth. May include procedures she would like to avoid (for her and baby), notes about breastfeeding and baby rooming in, and even the way in which she would like to be spoken to and addressed during labor.
Doula	An experienced woman who helps other women around the time of birth. This is U.S. usage; the word actually means “slave” in Greek.
Epidural	Local anesthetic injected into the nerves coming out of the spinal column in the lower back area to numb labor pain.
Episiotomy	A surgical cut in the perineal muscles, measured in degrees to enlarge the vaginal opening.
Forceps	Large spoon-shaped metal tongs that are inserted into the vagina and cupped around the head of the baby, which is then delivered by pulling on the handles.
Maternity Period	The time from just prior to conception and lasting for approximately 6 weeks following childbirth.
Morbidity	Disease or injury.
Mortality	The number of deaths in a given time and place.
Normal / Natural ²	For introductory purposes the terms can be interpreted as referring to the biological and/or physiological process of childbearing.
Oxytocin	Hormone secreted during labor that causes uterine contractions. Synthetic oxytocin (called Pitocin) is given intravenously to stimulate labor in hospitals and sometimes by injection to stop a postpartum hemorrhage.
Parturition	The act of giving birth to offspring, which often includes the pregnancy period.
Perinatal	Pertaining to the time and process of giving birth or being born.
Perineum	The band of muscle between the vagina and the anus.
Puerperal	Woman in childbirth.
Rooming-in	Hospital practice of keeping mother and baby together.
Tokophobia	Dread of childbirth.
VBAC	Vaginal Birth After Cesarean, pronounced vee-back.

¹ Primary references for glossary terms include: Gaskin (2003) and Merriam-Webster’s online dictionary; however, the term tokophobia was defined by Hofberg and Brockington (2000).

² Both of these words and their use in maternity care culture are controversial and heavily debated in the literature at present.

AUTHOR'S STATEMENT

I believe that it is important to state at the beginning one of my guiding theoretical frameworks for this piece of work. Although stated in the title, I want to be clear what I mean by *feminist critique* and how the feminist tradition guided me throughout this inquiry. One key feature of both feminist and critical research that I employed during this process – from selecting literature to review to writing this paper and through my interviews – is the notion of uncovering and addressing hegemony (Madison, 2005; Prasad, 2005). Through this research process, and my own personal experiences, I have come to recognize that the maternity culture in the U.S. is just that, a hegemonic system. Madison (2005) referred to hegemony as, “the way in which dominant classes control and exploit subordinate groups by consent, thereby masking exploitation by convincing the exploited that their condition was natural to them, even good for them” (p. 53). Therefore, the research that I cite and the words that I write often will reflect this understanding and theoretical framework. When I use the word critique, my intended meaning is to question, to assess, or to appraise, but not to judge as it is sometimes misunderstood to mean.

Another key element of a feminist framework, which I employ, is the notion of exploring the “invisibility and exploitation of women” (Prasad, 2005, p. 159). These two features (a hegemonic system and the exploitation of women) help to highlight the guiding direction of this inquiry; however, they do not address my intention or my goals. Therefore, I would like to be very clear about my intention and my goals for this document.

It is my intention that by reading this dissertation, each of you will have questions about your own experiences and knowledge, whether or not you have given birth and even if you are male. This may lead to some discomfort or even anger at times, as challenges to both

one's experiences and one's understandings are often not easy. However, it is my greatest hope that if a reader experiences any challenges or a thought-provoking process as a result of reading this dissertation that s/he will dialogue with others about the topic and might develop new understandings and viewpoints about childbirth.

To be clear, the intention of this document is not to label any one experience as good or bad, right or wrong – as doing so would simply be more disenfranchising and oppressive. Rather, the purpose and goals are to leave the readers with more questions – questions about the maternity culture in the U.S.; questions about options, choices, and outcomes; and most of all questions about their own experiences. With this, it is also important to note that conversations around birth tend to draw these so-called lines in the sand around natural birth, medicated birth, home birth, cesarean birth, and so on. Although these issues and topics are most certainly explored in this inquiry it is not with the intention of claiming a superiority of one over the other, but rather bringing a critical reflection for the reader (and writer as well). My greatest desire is that this document might serve as a conversational starting point around these very issues, not to judge them, but rather to discuss their meanings and implications for women, their children and families, and our society as well as the maternity culture as a whole.

Additionally, it is important to state that although doctors and the medicalized model of care are addressed from a critical standpoint, this again does not mean any individual professional or the medical system as a whole is good or bad, right or wrong. There have been many scientific advances in medicine which have been unquestionably beneficial to women and children, as well as significant efforts made to humanize birth. However, the historical perspective of this document will reflect on the notion that men developed and

dominated the medical profession and in doing so women were often oppressed. The review of history is most certainly a feminist perspective, meaning that the oppressive and marginalizing elements during the founding, developing, and shifting times in medicine (and most specifically childbirth) are highlighted.

Most would likely agree that throughout world history women have been silenced and marginalized and their experiences subjected to gendered interpretation. In many areas of life, most people can see aspects of marginalization that continue to exist in our modern day experiences. However, when considering the context of childbirth it seems to be a greater challenge to recognize that such oppression may likely have also occurred. There are many possible reasons for this cognitive dissonance concerning childbirth experiences and I will not speculate about these reasons; the reader will have to consider his or her own reflections as to why this may or may not be. I note this simply to state that once again, this is not always an easy topic to approach in a critical way; however, I believe it is necessary to do so if change, growth, and shifting are going to occur in maternity experiences in America. The intent of this critique is to draw attention to the role of socio-cultural and other systemic influences on childbirth. So I invite you, dear reader, to read on with an open mind – knowing that my goal is to affirm all women and their experiences during their time of maternity.

BACKGROUND INFORMATION

In 2009 I conducted research for a mini-thesis project as a requirement in the Department of Human Development and Family Studies at Iowa State University. The paper, *Maternal Perceptions and Experiences with Pregnancy and Childbirth* (Hardy, 2010), was a phenomenological project in which seven women shared with me their stories about their birth experiences. Four themes were developed as a result of interviews, which included (a) relationship with provider; (b) confidence, doubt and trust; (c) decision-making power; and (d) maternal feelings of empowerment. Throughout my interviews with these women I found myself frequently surprised, particularly at the way women described their experiences as involving such blatant power hierarchies. More so, I was surprised by the way women seemed to dismiss their own personal feelings resulting from their interactions within these apparent power structures. I would often find myself reflecting on questions of “why” following interviews. Why did she do this or not that? What, who, or how were decisions influenced? What made her feel this way or that? and so on. Specifically these “why” questions were paramount when the women participants would make a statement like, “Well, I don’t know. That’s just what you do.” I was particularly moved by a conversation in which a woman indicated that despite adamantly not wanting a procedure she believed she “couldn’t” say anything to her provider. I asked myself, “How did we get here?” and “What occurred to make ‘just what you do,’ well, just what you do?” In addition to the systemic power dynamics that I briefly addressed in this mini-thesis, I wanted to explore some of these questions further, for at the time, they were simply of personal interest to me. In my personal search I discovered that answers to these questions and the potential implications of their answers were significant. And it is from these experiences that the current project

developed. This project was an attempt to integrate what I came to understand from my mini-thesis project and my personal quest to understand the how and why of birth in America.

CHAPTER 1 GENERAL INTRODUCTION

Giving birth constitutes what anthropologists call a rite of passage: it is the point at which a critical and deeply personal life transition occurs from one stage to another, a transition that occurs when a life boundary – the moment that divides two stages of life – is crossed. (Eakins, 1986, p. 3)

Few would argue that the creation of a new member of our social world (i.e., having a baby) is an experience which is deeply life-changing. However, having a baby in America appears to be far more complex, than *just* reproducing social members of our world. Simply put, this means that the processes of reproduction do not occur separate from the influence of the social world and vice versa. What many women may not notice is that their individual childbirth experiences are profoundly influenced by history, socio-cultural politics, and propaganda, all of which serve as a very powerful undercurrent guiding the very course of their deeply personal life-changing experiences. For the purposes of this research, this undercurrent which I am referencing is best understood as the maternity culture in America. This maternity culture, as I define it, includes specifically the maternity care system and the individuals who interact with the system in various contexts. Simply put, the maternity care system or culture is not viewed (in the context of this study) as a closed system, but rather one which operates within and is also influenced by a diverse network of micro and macro systems.

In the past decade many scholars, policy makers, and individuals have indicated that the United States is experiencing a maternity care crisis (Baker, 2005; Davis-Floyd, 2006; Declercq, 2009; Lothian, 2009; Wagner, 2001). Some of the justification for this claim includes the rising rate of medical intervention (induction, anesthetics, analgesics, and cesarean) and the safety of childbirth in America (Declercq et al., 2008; World Health

Organization, 2007). The World Health Organization (WHO) data from 2007 indicates that the United States is ranked last out of 16 comparable industrialized nations on maternal mortality and fifteenth for perinatal mortality rates (Declercq, 2009).

Although these grave data are certainly convincing evidence of a “crisis” in maternity care, simply having more women and infants surviving, which would improve our ranking as a nation, does not necessarily mean that the woman’s individual experience improves. In fact, these data do little to offer insight into the personal feelings and experiences of women (and babies) as they enter into, and attempt to successfully navigate through, the maternity culture in America. Additionally, these reports on safety offer only a small, albeit significant, portion of the picture of maternity experiences in this country. Is a successful experience measured only by way of mortality – is that enough to deem one’s experience successful? What about the individual woman’s psychological experiences – the way she internalizes her deeply personal and life-changing experiences?

Robbie Davis-Floyd (1994) suggested that over the course of the last century the medicalization of childbirth has disembodied women. What Davis-Floyd suggests is that women have essentially been reduced to being merely living vessels for a product (the baby), rather than a holistic (living, breathing, feeling, and thinking) being. Foucault (1973) used the term “medical gaze” to describe the dehumanizing way in which medicine separates the patient's body from their being. Rothman (1989b) uses the words “medical ideology” to describe the way in which technology is idealized and privileged and as such is “part of the hegemony” (p. 51), which does “harm to the human spirit” (p. 54). Is the woman as a unique being lost in the undercurrent?

Does addressing the goal of improving mortality rates account for her – the holistic being (woman and mother) – or simply consider “good” outcomes by way of improving “the numbers?” Who is she, where is she, what is she thinking and feeling, and how is she coming to understand and making meaning, while she navigates the waters? It is important to consider that during her tenure within the maternity culture, ultimately the task set before her is one of becoming – to make the transformation to mother. Through her experiences she is being changed and is changing simultaneously, a task, which in itself is not a small (or insignificant) one. Therefore, it is my belief that it is necessary to ask and critically reflect on this question: How do women feel about their experiences and most significantly, how do they feel about themselves following their journey through the maternity culture in America? Do women feel disembodied or disempowered by their experiences, as Davis-Floyd (1994) suggests, and if so, why is this occurring and how can it be improved?

This research was aimed at gaining an understanding of the ways by which women come to recognize, understand, and feel influenced by their maternity experiences. In doing so, it was a primary goal of this research to come to know what women’s maternity experiences are (hear their stories), but also how they internalize their deeply life-changing and personal experiences. Through listening and privileging the experience and stories (voices) of women, there is a potential to impact the lives of women who will enter the waters of the maternity culture in the future. By affecting the future consumers of maternity care in America, the system itself will likely, inevitably, be changed as well. Naturally, the hope is that it will be a change for the better! Therefore, the purpose of this research was to understand the personal meanings of women’s birth experiences in America. I specifically

explored issues of power and disenfranchisement as well as sought to understand the role of socio-historical influences, which are deeply interwoven within the American story of birth.

Theoretical Perspective

Goals of Feminist Research

Feminist researchers employ an emancipatory framework based on the assumption “that those who live their lives in marginal places of society experience silencing and injustice;” due to this marginalization, there is an “absence of voice” (Brown & Strega, 2005, p. 21) in both research and reproduction of knowledge. Therefore, the goal of feminist research might be stated as the *liberation of voices* – to bring that which is unseen and unheard into the spotlight and in doing so, address injustice. Bloom (1998) stated, “Feminist researchers always have a political agenda of finding ways to better understand women’s lives” (p. 41).

It might seem somewhat odd to those unfamiliar to describe the maternity period, and specifically birth, as having anything to do with politics and political agenda, that is until one explores the various systems within which women interact during this period. For example, it is only legal in 27 states (in 2011) to practice as a certified professional midwife (CPM) or (i.e., to practice out-of-hospital birth). In the state of Iowa there is no legal licensure for a CPM. However, certified nurse midwives (CNM) are offered a license through the state. CNM’s are trained in both nursing and midwifery, while CPM’s are trained in midwifery only. In fact, if a woman gives birth (intentionally) without assistance of a certified professional (whether licensed or not) in the United States should could face legal ramifications (Hickman, 2010). These legal decisions are very political, and in turn, immediately remove power from the woman to make decisions from the broadest range of

possibilities about her body and birth experience. It is necessary then to consider the legal and financial requirements maternity care providers are obligated to address in order to practice in their field of medicine (the medicine of reproduction and birth). Maintaining a professional license requires access to and availability of higher education. In order to practice in the community a provider must obtain insurance, including malpractice, and in doing so the professional is then required to comply with the demands (i.e., which procedure can be performed) of the company offering the insurance coverage. Beyond this the clinic or hospital in which the provider will work also will have rules and regulations which must be followed in order to practice in that setting. Keep in mind none of these requirements for medical practice have yet to address the needs of the patient (the woman) and her best interest, not to mention her wants, needs, and desires, for her experiences during her maternity period. This is not to say these practices (licensure, insurance, and policy) are not well *intended* for the patient's benefit. It is not difficult to assert, however, that these practices may very well be in the best interest of the professional rather than of the patients (women).

Therefore, I think it is easy to say the experiences of women during their tenure in the maternity culture are deeply political. Harding (1987) suggested that the political struggles of women are often the primary starting point(s) for feminist inquiry. Therefore, this is where I will also start; I will explore and seek to understand (a) the social and historical contexts of how what is now the model of maternity care in America came to be, and (b) how this model of "care" influences the lives of women today.

Finally, Bloom (1998) offered some possible goals to consider when using feminist inquiry to guide research. I chose to embrace these goals as guiding principles for my work;

they are as follows: (a) to further our understanding of women's lives and experiences, (b) to challenge dominant modes of participatory research, (c) to actively contribute to social change, and finally (d) to generate reciprocal caring for the well-being of each other as whole beings.

Assumptions of Feminist Research

One assumption of feminist inquiry, like many other forms of qualitative research, is that of multiple ways of knowing (epistemological) and challenging the idea of a singular truth and one reality (ontological). Reinharz (1984) (as cited in Brown & Strega, 2005) suggested that feminist researchers emphasize inductive thinking, which is based in the subjective and lived experiences of women. Feminist research attends to the way in which knowledge is produced and reproduced and recognizes that there are many different (subjective) truths as well as multiple realities. In this inquiry, specific attention was paid to the ways in which knowledge is produced and reproduced as well as the multiple sources of these productions.

CHAPTER 2

REVIEW OF LITERATURE

We are what we think. All that we are arise with our thoughts. With our thoughts we see the world. The Buddha

When one considers the history of childbirth, it is important to recognize that most of world history has been written, shaped, and directed by men. Rich (1976) reminds us in her text *Of Woman Born* that historically women have not been the “makers and sayers of culture, the namers, have been the sons of the mothers” (p. 11). This is surprisingly true – men as sayers –when we consider our collective knowledge (and practices) regarding birth. As stated in both title and introduction to this piece of inquiry, the feminist perspective has guided my process significantly. I note this again here as it is important to be aware that particular attention has been paid to the experiences in childbirth history which have lead to marginalization of women. Simply put, this historical review may in some ways seem to be distorting what we (in the twenty first century) *believe* to be *true* about birth practices, when, in fact, this is not the case. The fact is this review is not a distortion, but rather sheds light on a portion of women’s history which often goes untold – a portion of the American story of birth which is often left in the margins.

With this is mind, through this review of literature I also attempt to highlight the way society has constructed our modern understanding of birth. The social construction of birth³ is a deeply embedded, interwoven, and even directive, factor which is ever present in our

³ Barbara Katz Rothman contributed a chapter, “The Social Construction of Birth” to Pamela Eakins’ (1986) edited book, *The American Way of Birth*. I borrow Rothman’s title here as I feel it is the most appropriate and simplest way to conceptualize the presentation that will be made in the forthcoming section. I find it most appropriate to acknowledge the women, who will be cited elsewhere in this text as well, with penning the phrase which I use today.

culture's past and present representations of birth. Jordan (1980) reminded us that childbirth is a biological experience mediated by culture. Our culture and socialization processes *made (constructed)* birth in America this way. Birth is therefore much more than a physiological or biological event; it is very much a psychological and social creation. Rothman (1986a) added that birth, like anything else, is therefore both “socially constructed and defined” (p. 105). Fish (1990 in Crotty 2003) added that we do not recognize things as they are (simply as being); he suggested that recognition only comes when one is told. Therefore, it is necessary to explore what American society and culture are constructing – telling – when it comes to childbirth experiences.

It is often assumed that modern day medical practices – or for that matter anything which is considered normative – are carried out or performed because they are the most technologically-advanced, scientifically-proven, and evidence-based, and therefore, *the best*. It seems noteworthy to reflect on the notion of the concept sometimes referred to as *The American Way*, an apparent ideology of the United States that as a nation we are the best, have the best, and so on. What I hope to present here is a brief picture of the way in which society and science have *both* constructed the image and practice of birth as we know it today. With all of this in mind, I present to you a brief history of childbirth in America.

A Brief History of Childbirth in America

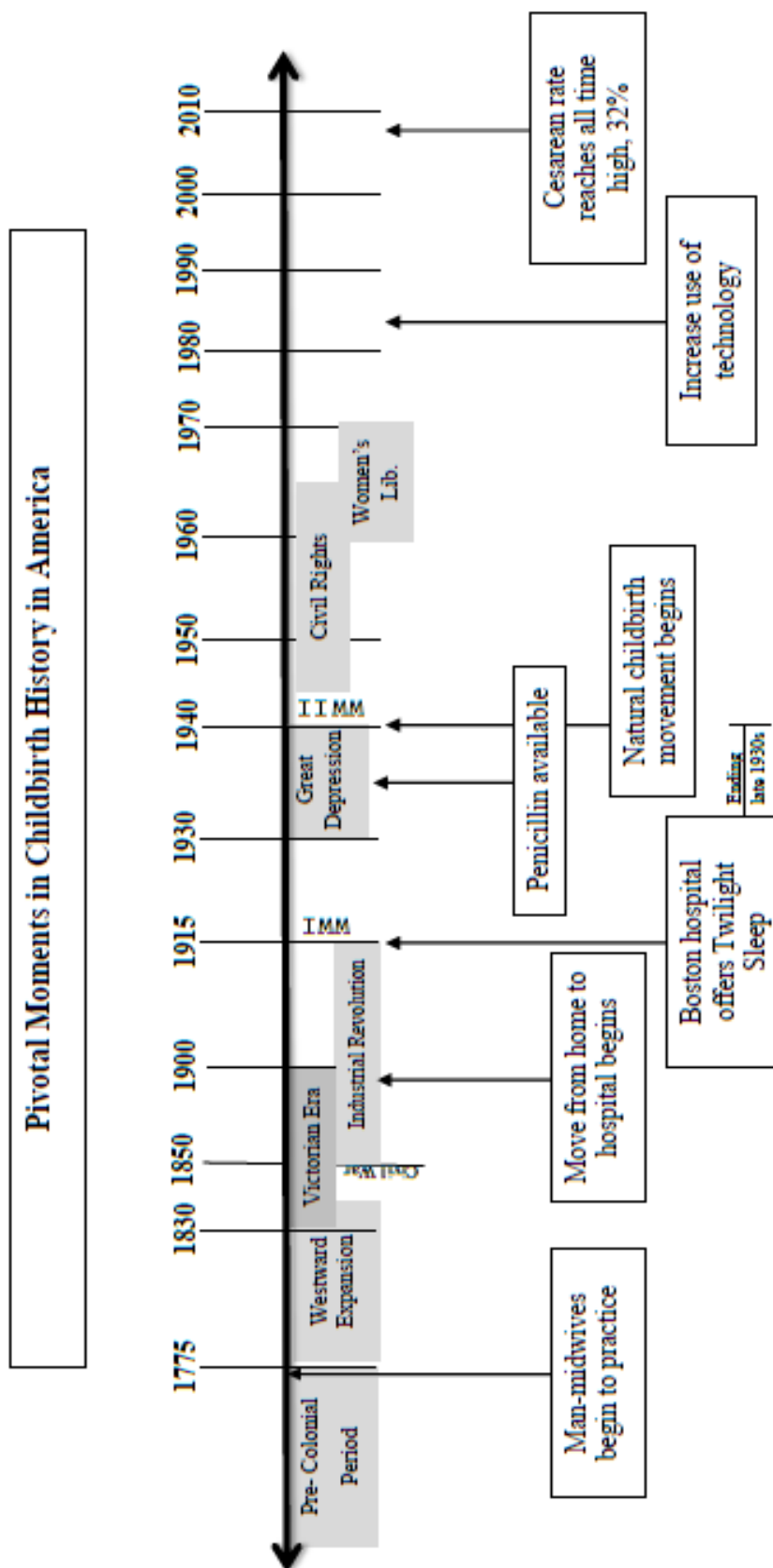
All human life on the planet is born of woman (Rich, 1976, p. 11).

The history of world events is often heavy with theological and philosophical debate, but one thing has always remained fairly certain -- women give birth. Until recently (the past 100 or so years) women gave birth at home with the support of other women. In addition to family and community who might gather to support a woman during and after her birth, often

a midwife was present. An American woman today (2011) will most likely have a drastically different maternity care experience than her mother or grandmother had just 20-50 years prior. From the moment she finds she is pregnant she will be bombarded by information (some self-sought, some not) regarding all the things she can and cannot or should and should not do if she desires to have an optimal “perfect” child, which she does. The typical birth experience will take place in a hospital, without family, other than a partner or perhaps one other support person present. The number of people allowed in the room at any given time and at what times is usually dictated by hospital policy or is specific to the attending provider.

In 1900 less than 5% of women gave birth in a hospital and in 2008 slightly less than 5% of women gave birth at home (Eakins, 1986; Scelfo, 2008), a complete reversal. In those 100 years, some things certainly have changed for the better in childbirth and in the process a few things may have been lost *or ignored, or suppressed* for the worse. While scientific, medical, and technological advances were being applied to childbirth practice, often called the process of medicalization, historians have reported the social experience, normalcy, and concern for the holistic well-being of women may have been lost in the process (Goer, 1999; Pollock, 1999; Towler & Bramall, 1986; Wagner, 2001). Some have criticized the American birth experience, calling it dehumanizing; the critics suggest that the experiences are disembodied, considering women simply as vessels for a baby, rather than holistic beings (Davis-Floyd, 1994; Eakins, 1986; Wagner, 2001). Wagner (2001) wrote, “humanizing birth means understanding that the woman giving birth is a human being, not a machine and not just a container for making babies” (p. 25). When this holistic philosophy of care is missing, a negative ripple effect can impact women, developing children, and society (Davis-Floyd,

Figure 1: Timeline Representing Pivotal Moments in U.S. Childbirth History



1994; Rothman, 1989). So, how did we get here? What social, political, and cultural events influenced the process of constructing birth in America? Figure 1 is a timeline I created to briefly summarize and represent some of the content which will be discussed in this chapter, as well as one means to begin addressing the question of how we got here.

Birth in Colonial America

In 1977 Richard and Dorothy Wertz wrote the first definitive social history of childbirth in the United States. Since the first edition the two anthropologists, neither with particular agendas (i.e. political or social) regarding medicine or childbirth, have twice revised their *Lying-In: A History of Childbirth in America*. Prior to the publication of their book, the history of childbirth as a social construct had not yet been explored by historians. Since their first edition several others (see Block, 2007; Eakins, 1986; Rothman, 1982) have written social histories of birth, as well as other critical analyses of the experiences of birthing women in America, but their was first. They covered about 370 years of history and describe experiences of birth in the U.S. birth up to the late 1980s. Although experiences have continued to change and evolve from a cultural and political standpoint since the conclusion of their latest edition, we continue to be in a somewhat similar position today. Therefore, their book remains an appropriate – and frequently cited - source of reference when one explores the social and historical context of birth in America.

Wertz and Wertz (1989) reported that during the colonial period, and for the succeeding 150 years, childbirth was “the exclusive province of women.... Women attended and aided each other during birth itself and during the several weeks of ‘lying-in’ that followed” (p. 1). Until the mid eighteenth century American women primarily gave birth at home with the assistance of other women. Typically, those who assisted them during birth

were relatives and friends; however often a trained midwife was present to attend and provide care. At this time, midwives were trained through apprenticeship, as there was no formal medical (or midwifery) education for anybody, let alone for a woman. This “era” in childbirth, if you will, is often referred to as the period of *social childbirth* (as coined by Wertz & Wertz, 1989), for during this time birth was considered to be a typical, everyday social event in the lives of women. Wagner (2001) stated that birth during this time was “humanized as it kept the woman in the center and, in general, respected nature and culture” (p. 26).

In the mid eighteenth century American men began to presume a role as childbirth attendants. It was at this time that many men, having returned from medical training abroad (primarily in England and France), began to practice what was referred to as the new midwifery. Prior to this time both medicine as science and men were not included in the practice of birth. The entrance of men as birth attendants in the realm of childbirth was a pivotal shift in the practices and beliefs regarding birth in this country.

One key element that practitioners of the new midwifery, also called man-midwives, brought to the birth experience was the use and invention of instruments or tools. Whether or not they were beneficial to the women in labor (and often they were not), the simple possession of specialized tools was something that the man-midwives used to their benefit. The possession of an instrument implied an ability to *do something*, and the user of the tool had an implied ability to use it for the betterment of a given situation. The man-midwives must have been well aware of the need to promote this assumption, for their livelihood depended on it. Davis-Floyd (1994) noted that during this time (and perhaps continuing

today) the social and cultural belief that technology is better than nature was a crucial factor in spurring the rapid changes in childbirth that occurred over the next century.

In order for the shift from social childbirth and traditional midwifery to the practice of the new midwifery (what would eventually be called obstetrics) and the medicalized model of care to occur, several assumptions had to be socially accepted: (a) technological progress is good, (b) science can improve nature, and (c) birth is a pathological event. Although man-midwives/doctors alone were not responsible for the social acceptance of these assumptions, they most certainly were adamant promoters of them to their benefit (i.e., for income and status). Joseph B. DeLee (1920) was a prominent, outspoken, and popular physician who wrote that “labor is pathogenic, disease-producing, and anything pathogenic is pathological or abnormal” (p. 35). DeLee might be best known in the obstetric community for his 1920 article titled “The Prophylactic Forceps Operation.” At this point one may begin to question who benefitted from the course of changes that occurred in maternity care during this period. This history is the foundation, the very basis, for modern day maternity experiences and must be noted as such.

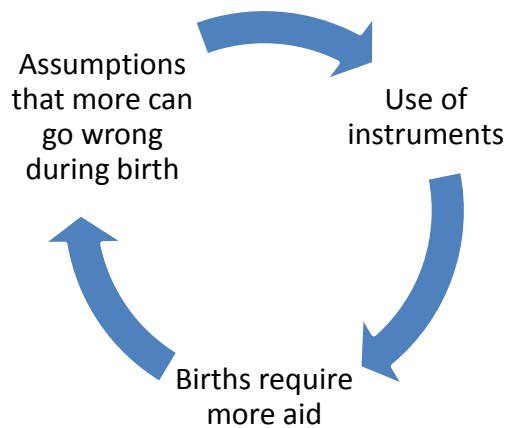
he·gem·o·ny: The way in which dominant classes control and exploit subordinate groups by consent, thereby masking exploitation by convincing the exploited that their condition was natural to them, even good for them. (Madison, 2005, p. 53)

Doctors felt that their patients and the patients’ families demanded that they demonstrate their skills and necessity as birth attendants (Scully, 1994). Dr. Channing (1848), a professor of midwifery at Harvard, stated that “[the man-midwife] had to use his arts [instruments] because he was expected to ‘perform,’ even though he has been trained to know that nature is adequate, but slow” (as cited in Wertz & Wertz, 1989, p. 64). It is worthy to note that even the earliest proponents of medically managed birth agreed that

nature was adequate and even pointed to the issue of “trouble” lying not with the process of birth itself, but the impatience of the attendant.

Due to this perception of demanding performance, Scully (1994) wrote that as more and more “instruments were used [during deliveries], the more it appeared they were necessary” (p. 30). Scully suggested that perhaps there was not a *need* for the increase in aid, but rather a *need* to appear skillful, useful, and necessary. Although records mostly were not kept during this time, from what is available it is indicated that there were a large number of instrumental deliveries and some of the reasons given for the necessity of aid include the woman’s laziness, stupidity, or her inability to finish a birth (Wertz & Wertz, 1989). As the use of instrumental aids during birth increased, a shift in the apparent perceptions of women also occurred. The assumption that more could go wrong with a birth also began to make its way into the social conversation around this same time. Furthermore, there also seemed to be a greater focus on pain during birth. Kass (2002) wrote about the history of midwifery in Botson and featured the biography of a prominent figure, Dr. Walter Channing. Kass indicated that “Instrumental births were certain to be extremely painful” (p. 156). Scully (1994) cited Dr. Samuel Gregory’s writings (circa 1884), “The introduction of men into the lying-in chamber, in place of female attendants, has increased the suffering and dangers of childbearing to women, and brought multiplied injuries and fatalities upon mothers and children” (p. 27). This seems to be a classic rhetorical conundrum, which is especially relevant when we reflect on modern day perceptions of childbirth. The model below (see Figure 2) is a representation of the way in which both society and science interact and in doing so construct our understandings (and performances) of birth.

Figure 2: Representation of the Circular Logic of the Use of Instruments in Birth



In addition to the instruments and specialized training in the new-midwifery, selecting a male doctor as a childbirth attendant also came to be viewed socially as a more *respectable* decision. This belief needs to be noted as a significant part of this social-cultural-historical conversation. It is important to be aware that in the early part of the eighteenth century only men, and more importantly men who could afford it, could get any education and specifically a medical education. The men who had a medical education were seen as respectable gentlemen and therefore, the most appropriate attendants for *proper* women. Their education also justified their higher fees – over midwives – for attending a birth.

It was not until 1847 that the door for women to attain medical education was opened. Elizabeth Blackwell, after having applied to 29 other schools, was the first woman accepted into an American medical school in New York. Then, in 1864, Blackwell, along with her sister, opened the first American medical college for women. However, women's entering the medical profession may still be questioned as to whether or not it was necessarily a positive step for women's childbirth experiences. For any women in medical

school would be trained in the new midwifery, which operated under the notion that science was superior to nature and instructed on the medical model of care, rather than traditional midwifery, which for the most part held the belief that nature was sufficient. Reyes (2007) agrees that obstetrics is a “traditionally male-dominated” (p. 407) profession and indicates that only in the past decade, in 2001, that women actually surpassed men as the main providers of obstetric care in the United States. Regarding this matter of dominance over the profession Scully (1994) writes:

In order for obstetrics to establish its claim and eliminate women midwives, childbirth, whether complicated or normal, had to be considered and defined as a pathological state requiring the intervention of obstetricians [men] and their instruments and surgical techniques . . . prospective mothers had to be convinced that normal pregnancy and childbirth were exceptions and that to consider them normal physiological events was fallacious. (p. 29)

Maternity Hospitals

In the long [run], the development of maternity hospitals was to benefit obstetricians more than mothers and babies or midwives. It was ultimately to confirm the ascendancy of the male doctor as birth attendant, to establish his dominance in the management of childbirth and to change the concept of reproduction from being a natural condition, appropriately completed in a domestic setting, to a pathological condition, appropriately completed in a medical situation. (Tew, 1998, p. 46)

The first maternity hospitals were free-standing institutions, not the multi-disciplinary collaborative spaces (i.e., the maternity ward) we associate with hospitals today. They were established for charity in the seventeenth and eighteenth centuries in various large cities and towns, first internationally, then in America as well. The hospitals offered obstetricians clinical research and training opportunities which they could not gain on their paying and *proper* clients. The homeless and poor women who were invited to give birth in the maternity hospitals were frequently exploited and subjected to inhumane treatment in the

name of medical science and the advancement of the profession. The experiments these women were subjected to were carried out in the name of education and the betterment (of birth) for all women (or at least those who could pay). These first hospitals offered pregnant women shelter, food, and rest; however, their time there likely had a cost greater than that which could be measured (Towler & Bramall, 1986).

The Move From Home to Hospital

Women [moved to the hospital] at the expense of being processed as possibly diseased objects. Thus began the major transformation in birth: from home to hospital from suffering (sic) to painlessness (sic), from patient [and woman] care to disease care. (Wertz & Wertz, 1989, p. 128)

In the early part of the nineteenth century maternity hospitals were a place where poor or homeless women gave birth. To give birth in a maternity hospital was a representation of low social status, if not worse. Maternity hospitals recognized that if they wanted to serve more women – more paying women – in this centralized location there was a need to improve their image. They went about working to change the perception that they were a place of degradation – of and for the *lower class*. One way they worked on this image was to associate with medical schools, rather than operate as free-standing independent facilities. In doing so, they became clinical labs, places for testing, and a forum to try new instrumentation and operative procedures. However, for the most part the primary clientele of the maternity hospitals remained women of a *lower social class* than doctors, thus making it easier to justify the treatments and experimentation on their patients to the advancement of their skill.

Doctors became more concerned with treating illness and disease than with the previous moral therapies they had been dispensing or having involvement in the patient's life. Previously, doctors had to earn the trust and respect of the entire family in order to see

patients and maintain a business. This meant that they had to personally come to know their patients, and their family, in a way that was more intimate and personal than the doctor-patient relationships with which we are more familiar with today.

Doctors were now able to view the charity patients in maternity hospitals as simply a case, rather than a person – a woman and her family, whose trust needed to be gained. This would have proved difficult with more genteel women (private⁴ patients) who expected modesty and more supportive care. Doctors – who had money and had organized professionally unlike most midwives – were able to spread their claims⁵ of the hospital as the proper, appropriate and best location for birth. Additionally, doctors increasingly desired to practice solely in the hospital (their territory), since this was where they had easy access to their various instruments of birth and could perform – demonstrate their skill – their medical arts in their own space.

Eakins (1986) described the territory or turf (location) in which the act of giving birth occurs as a “sphere of control” (p. 4). Although it may be somewhat a parenting or social joke in U.S. culture to use an expression such as “my house, my rules” or “when you are under my roof,” Eakins implied this type of sphere of control when discussing birth territory. The one on whose turf the act of birth is taking place is the one who makes the rules and therefore, holds the power. A woman (patient) has the legal right to refuse any treatment option offered by a provider in America. However, a provider can refuse to provide an alternative treatment option to a patient refusing the recommended one. Take for example a woman stating she does not want a repeat cesarean. The provider’s hospital, as well as

⁴ Wealthy independently paying clients.

⁵ The following section, on propaganda, will discuss this message, and its implications, in further detail.

malpractice insurance, may not allow (i.e., have a policy) the woman to give birth vaginally if she has had a previous cesarean (known as a vaginal birth after cesarean, VBAC).

Therefore, despite her right to refuse the recommended treatment (repeat cesarean), a provider – the hospital and insurance companies - ultimately leave her without the option to refuse. The woman has little choice but to comply. However, if the woman has the means (financially) to seek an alternative provider and *location of service* only then does she truly have the choice to decide whether or not she can give birth vaginally (Block, 2007).

Eakins (1986) wrote that, “hospitals often reflected the best interests of those who provided the service” (p. 4) – on whose territory the act of birth was occurring. Wertz and Wertz (1989) added that, “Routines were devised for the convenience of the workers rather than of the patients” (p. 167). The location of birth in the hospital also relieved the doctors of the role of comforter and confidant, as chaplains, nurses, and social workers were readily available to fill those social roles. This would allow doctors to “use their skill more efficiently” (Wertz & Wertz, 1989, p. 145). Additionally, the hospital provided a space for doctors to continue to experiment with new instruments and procedures, while also upgrading and organizing the profession of obstetrics.

If a woman wanted the artful assistance of a doctor during her birth – as any *proper* women would – she had no choice but to go to the doctor and the hospital. Tew (1998) wrote, “the strength of forces propelling [women] in that direction left women with little alternative” (p. 17). In 1900, less than 5% of births took place in a hospital; by 1921 approximately half of all births were in the hospital. As midwives were being eradicated from practice, hospital births continued to increase (Wertz & Wertz, 1989). Based on this historical information it is apparent that the move to the hospital was not based on evidence

of better care, but rather was a result of a persistent propaganda campaign that left women with a lack of options for themselves. Ultimately social perceptions shifted, thus creating a paradigm shift in how birth was performed and eventually what we have come to know about giving birth.

According to Cahill (2001), one eventual consequence of moving births to hospitals was the almost complete medicalization of pregnancy; medical frames of reference and knowledge have been accepted and legitimized within a system that has brought about not only a surge in engineering obstetrics but a steady erosion of maternal choice, control and satisfaction in relation to many aspects of pregnancy and labor. Although the trend continues to be justified in the name of safety, other factors are clearly at work in underpinning and sustaining the position. (p. 334-335)

It has been suggested that one key motivating factor for doctors to promote the move to hospital was the need to gain ultimate control of the laboring woman (Cahill, 2001; Wertz & Wertz, 1989). This need to control in order to be able to administer treatments led to doctors being

....On the lookout for trouble in birth...they found a lot of trouble – so much, in fact, that they came to think that every birth was a potential disaster and that it was best to prepare each woman for the worst eventualities. (Wertz & Wertz, 1989, p. 136)

This assumption led doctors to increase their control over their patients and the birth process.

Unfortunately, this left women with even less power and ability to actively participate in the birth process (Scully, 1994). Women were willing to relinquish both power and participation based on the notion that the doctors methods were, in fact, safer as the doctor both believed and claimed to be. These shifting attitudes and mentality about birth lead to procedures, policies, and various protocols to be introduced, which were often not based on any empirical evidence and were likely significantly alienating and dehumanizing for women. Cahill (2001) indicated that “the shift towards 100% hospital delivery took place in

the absence of evidence of any perinatal or neonatal advantage or increase in maternal satisfaction” (p. 339). Wertz and Wertz (1989) offered the admission routine at Sloane Maternity Hospital in New York as an example of the birth routines and rituals which were customary in American hospitals at the turn of the twentieth century:

Each patient [a laboring woman] received an enema immediately upon admission and then a vaginal douche with bichloride of mercury, the favored antiseptic. Nurses then washed the woman’s head with kerosene, ether, and ammonia, her nipples and umbilicus with ether; they shaved the pubic hair of charity patients, assuming that poor people harbored more germs, and clipped it for private patients. They gave women in labor an enema every twelve hours and continued to douche the vagina during and after labor with saline solutions to which whisky or bichloride of mercury was added. The zeal against infection led to more douching than was really necessary or safe, for the solutions were ineffective against the germs and served to spread any infection that was already present. But the broad-gauged prophylaxis resulted in increased manipulations of the patient. (p. 138)

A key part of the history of birth in America is the fact that hospitals were “dirtier” than home and therefore, often more dangerous. In order for hospitals to achieve a “clean” environment the doctors needed to be extremely vigilant and this ritualized manipulations and interventions in birth. Wertz and Wertz (1989) indicated, “the hospital environment itself had contributed materially to defining birth as a dangerous event and to the treatment of each pregnant woman as if she might die” (p. 138). Cahill (2001) also indicated that the environment “reinforced the pathological nature of pregnancy and illustrates the controlling influence of medicine over women’s lives” (p. 335).

The Iatrogenic Condition of Birth

iat·ro·gen·ic: resulting from the activity of physicians; said of any adverse condition in a patient resulting from treatment by a physician or surgeon; Induced in a patient by a physician's activity, manner, or therapy; referring to injuries caused by a doctor; an iatrogenic disorder is a condition that is caused by medical personnel or procedures or that develops through exposure to the environment of a health care facility. (www.thefreedictionary.com)

The use of traumatic interventions during childbirth is of equal worth to note as was the spread of puerperal fever⁶ by attendants' hands. Wertz and Wertz (1989) stated:

The increased number of high- and mid-forceps operations, induced labors, versions, and cesarean sections created the "traumatized, devitalized tissues" that allowed the anaerobic streptococci already present to develop into infections, despite the creation of a sterile operating environment. It is quite possible that the fact that hospitals had infections as high as 11 percent in 1934 was the result not of carelessness about asepsis but of needless operations. (p. 127)

Tew (1998) statistically demonstrated that "there is absolutely no evidence that the routine use of interventions prevents the occurrence of emergencies. There is positive evidence that the routine use of interventions increases the dangers of death" (p. 32). She added that artificially disturbing any stage of the naturally ordered process of birth reduces the overall safety and efficiency of birth.

It is indeed possible that medicine's contribution towards overall standards of health and increasing life expectancy may be less than popularly assumed. But if this is so, how has the profession created a culture that clearly assumed and readily accepts a far greater contribution? Analysis of these strategies clearly reveals the importance of class and gender in the development of healing practices in the public domain. That the group of practitioners deemed unacceptable by the medical men included large numbers of women (whatever their craft, but largely midwives) is highly significant. (Cahill, 2001, p. 336)

This concept, which very well represents the iatrogenic state of childbirth in the U.S., is often referred to as the "cascade of intervention" (Inch, 1981, Appendix 5). The cascade of intervention refers to the concept that, as one intervention is introduced – which disrupts the nature ordered process – another intervention will be required, which requires another and so on; creating an iatrogenic condition.

⁶ According to current medical understanding puerperal fever is now known to be, and referred to as, an infection.

Wertz and Wertz (1989) concluded their chapter on “The wounds of birth” by stating that “puerperal fever is probably the classic example of iatrogenic disease – that is, disease caused by the medical treatment itself” (p. 128). It is not productive to speculate about the course of history in the lives of women and infants during this time if midwives had continued to be the primary providers of care during childbirth, for there is no point of comparison. However, as Wertz and Wertz pointed out

it is clear that doctors’ need to prevent puerperal fever contributed to the dehumanization of birth...doctors had to regard each woman as diseased, because birth provided the occasion and medicine the cause for infection...each woman had to be judged a potential victim needing preventive, and dehumanizing, treatment. (p. 128)

Wagner also commented that “the way in which technology has been presented [in birth] as necessary to ensure safety, [has] successfully glossed over any hint of iatrogenic outcomes” (p. 299) implying that the potential for negative outcomes from a technological intervention are often less emphasized and instead assumed to be beneficial and even necessary. As an example, we can look at the common side effect of taking any given medication, nausea. If a patient reports that they are experiencing nausea as a result of the intervention (medication) they can be prescribed another medication (intervention) to treat the nausea, which then may cause another side effect, leading to another medication and so on. Although, the original complaint may be somewhat or completely relieved by the first medication, the presence of the medication (intervention) has caused another problem to occur in the body – an issue which likely may not have occurred if the intervention had not been introduced. This, of course, is not to say that some persons may very well consider the relief of the original complaint to be *worth* the subsequent issues, but rather to offer a simple modern day example of iatrogenic conditions.

The Listening to Mothers II survey (Declercq, Sakala, Corry, and Applebaum, 2007), the second national survey conducted for Childbirth Connection in partnership with Lamaze International of women who gave birth in 2005, is “devoted to understanding experiences and perspectives of childbearing women” (p. 9). The survey asked women about their experiences with informed consent and informed refusal. Essentially, they explored if women understood, or had been informed, about the possible outcomes of a given intervention or procedure they had experienced. Interestingly they found that “most mothers stated that they had fully understood” (p. 13) their right to refuse a treatment or procedure. However, when mothers were then asked if they had declined any “forms of care” while in the hospital.

Despite the very broad array of interventions presented and experienced, widespread belief in the value of avoiding unnecessary interference, and a high degree of understanding about the right to informed refusal, just a small portion (10%) had refused anything. Of concern, the great majority of mothers who had experienced episiotomy (73%) stated they had not had a choice in the decision. (p. 13)

Additionally, mothers were then asked about their knowledge regarding potential side effect of various interventions (e.g., induction of labor, epidural, cesarean). It was reported that “Whether mothers had the specific intervention or not, they were poorly informed about a series of complications of labor induction and cesarean section; most had an incorrect understanding or were not sure” (p. 13).

A Propaganda Campaign

Because of the ill-defined nature of the medical profession in the nineteenth century and the poor quality of medical education, doctors’ insistence on the exclusion of women as economically dangerous competitors is quite understandable...[attending births] was a guaranteed income, even if small, and it opened the way to family practice...the family and female friends who had seen a doctor perform successfully were likely to call him again...Doctors worried that, if midwives were allowed to deliver the upper class, women

would turn to them for treatment of other illnesses and male doctors would lose half their clientele...Doctors had to eliminate midwives in order to protect the gateway to their whole practice. They had to mount an attack on midwives. (Wertz & Wertz, 1989)

pro·pa·gan·da: the spreading of ideas, information, or rumor for the purpose of helping or injuring an institution, a cause, or a person; ideas, facts, or allegations spread deliberately to further one's cause or to damage an opposing cause. (Merriam-Webster, 2010)

Throughout various historical documents on the topic of the history of childbirth, the word propaganda is frequently used to describe the events that took place primarily during the late seventeenth through the early nineteenth century (Dawley, 2000; Eakins, 1986; Tew, 1998; Wertz & Wertz, 1989). Dawley (2000) states, “physicians’ efforts to abolish midwives are well-documented” (p. 50). Some argue the propaganda continues today (e.g., legalization of midwives and location of birth), although others suggest the message has long been received and has now become *truth* in America’s knowing about birth, and as a result the message of that campaign is instead being unknowingly re-inscribed by the consumers themselves.

The move from home to hospital was a major factor in ultimately determining who would control birth. It has been argued that centralizing birth in the hospital, not only allowed doctors to control their work space (territory) but also offered them significantly more convenience. Wertz and Wertz (1989) wrote:

Traveling to women’s homes, remaining during the period of labor, and becoming involved in family life were time-consuming and a compromise of medical authority. The doctor had to defer to family wishes about interventions and inevitably, could not have with him [all of] the tools with which to demonstrate his skills. (p. 144)

Doctors gained both financially and by way of social status by achieving dominance as the providers of maternity care. Dawley (2000) writes that, “obstetricians wanted control

of these births as they sought to gain respectability for their specialty” (p. 50). However, they were up against a long (world) history of women as birth attendants. In order for them to accomplish this goal, they had to (a) create a need, (b) argue that they were the only ones to fulfill the need, and (c) eliminate any competition, especially competition that would call their necessity into question. The propaganda against midwives⁷ encompassed all three of these tasks. Their campaign was simple really-- convince women (mothers) their bodies were not capable of safe and successful birth without skillful, *scientific and medical* assistance and that they (the male-doctors, originally) were the only ones properly trained to accomplish what the woman’s body could not do.

Some have argued that women chose to birth in a hospital “with their feet” (Tew, 1998, p. 17); as a response to that claim, Tew argued that women had little choice but to go to the hospital. What is being suggested by Tew, among others, is that there were many forces propelling women towards the hospital and to diminish the role of these forces (e.g., social, cultural, and political) is to miss a big portion of the picture. The forces of these undercurrents are extremely powerful and should not be ignored as significantly influential in the shifts that occurred in childbirth. More specifically, one should not underestimate the ways these forces shaped and constructed what we know, and believe, to be the *reality* about childbirth and its history in America.

In 1998, Majorie Tew wrote in her book *Safer Childbirth?* the propaganda campaign was falsely based on the notion that medical specialists (i.e., obstetricians) and birth in the hospital were safer for both the mother and the child. Cahill (2001) wrote that there was “. . .

⁷ Although historical accounts document a campaign against midwives, I would also argue that in many ways this was a campaign against women and their right to make choices about their bodies, babies, and births. It was also a campaign which sent a profound message to woman regarding their bodies (and therefore, their very nature) as incompetent, incapable, and incomplete.

a largely consistent and persuasive argument from the obstetric establishment that the hospital is the best and safest place for babies to be born” (p. 334). Consequently, no one *ever* (until Tew in 1977) conducted any statistical analysis to determine if this notion (safety and hospitalization claims) was in fact true; it turns out the claims were, in fact, not true! Cahill (2001) also confirmed Tew’s reports by stating that “much of [the claims] occurred in the absence of any systematic evaluation of their efficiency or effectiveness” (p. 335). However, the campaign was a powerful one, and the claims were ones that the general public (and the medical professionals) wanted to believe. Recall, figure 2 on page 25 representing the circular logic of maternity culture change. One of the cornerstones of the medical professionals’ claims to safety was the coincidental trends of improved mortality rates (Schram, 2005). As hospitalization of birth and obstetricians as primary birth attendants were both increasing, mortality rates also improved, but Tew (1998) statistically demonstrated (several times over), as have others since (Johnson & Daviss, 2005; Schram, 2005), that these trends were coincidental, not causal as the medical professionals claimed (Cahill, 2001; Dawley, 2000).

The most frequent cause of death, prior to around 1870, was infectious disease. As living conditions began to improve both the spread and risk of infection diminished⁸. Additionally, as living conditions improved overall health improved and therefore increased survival rates (not just in birth). The fact that these trends occurred during the same time period that man-midwives were gaining more control over birth and birth in the hospital was being promoted were, simply put, coincidental.

⁸ Penicillin did not become readily available until the mid 1930s. However, it was in the 1840s that Oliver Wendell Holmes first suggested that infections were being spread from person to person and recommended that specific hygiene precautions could/should be taken to address this.

Tew (1998) indicated that at the time of the move from home to hospital was occurring “at every level of predicted risk [for birth] measured, high and moderate as well as low, perinatal⁹ mortality was highest by far for births in hospitals and lowest for births at home” (p. 336). What this means is that regardless of how “high-risk” a pregnancy was measured to be, births were safer at home than in the hospital. When the findings were first published in 1983, Tew stated that it was too late to influence the course of events, because total hospitalization and medicalized management of birth was already a solidified notion as *best* practice for birth. Tew’s findings, along with other studies comparing out-of-hospital to in-hospital birth, continue to be controversial today.

Johnson and Daviss (2005) are responsible for conducting the largest study to date exploring planned home births in North America (n=5418). They indicated that there is a “wealth of evidence supporting planned home birth as a safe option for women with low risk pregnancies” (p. 1416). In their 2005 study there were no maternal deaths and a neonatal death rate of 1.7 per 1000. This neonatal death rate is “consistent with most North American studies of low risk hospital births” (p. 1417). Additionally, it was reported that

Compared with the relatively low risk hospital group, intended home births were associated with lower rates of electronic fetal monitoring (9.6% versus 84.3%), episiotomy (2.1% versus 33.0%), cesarean section (3.7% versus 19.0%), and vacuum extraction (0.6% versus 5.5%). (p. 1417)

Johnson and Daviss also report that “a meta-analysis of the latest research in Britain, Switzerland, and the Netherlands have reinforced support of home birth” (p. 1419).

In discussing the long term ramification for women, children, and families of this propaganda campaign Wertz and Wertz (1989) wrote,

⁹ Pertaining to the time and process of giving birth or being born.

“Expectant and laboring women lost a great deal from the exclusion of educated female birth attendants. . . . As an initiation rite of women, birth became a moral test and a physical trial in which the male doctor, not merely the company of women, judged a woman’s passage into adult society.” (p. 73)

Tew (1998) added that “civilization seems to have robbed women of the certainty of a safe, pain-free, uncomplicated delivery, just as intensive stock rearing has done with farm animals” (p. 40).

The Birth of Surgical Birth

Birth in the hospital continued to be defined as perilous and pathologic condition requiring frequent manipulation and intervention; *many might argue that it still is* (see Block, 2007; Trevathan, 1993; Wagner, 2001). Justification for such invasive procedures and the increased apparent necessity for instrumental deliveries continued to be frequently attributed to the woman’s moral character. Wertz and Wertz (1989) reported that a review of a Boston maternity hospital in the 1890s cited “patients as too lazy or too stupid to deliver by themselves,” (p. 139) hence requiring the interventions and instrumentation. They also noted that the use of such interventions can be explained as “expressions of impatience” on the part of the doctors (p. 139). Of course, there were many occasions when interventions were, in fact, humanitarian and necessary. One of these potentially beneficial and life-saving interventions was the cesarean delivery¹⁰ (also called the cesarean section, c-section, or section).

The first successful cesarean delivery in the United States is said to have taken place at a Boston hospital in 1894. By 1913, the director of the Sloane Hospital in New York had

¹⁰ I will use the term cesarean delivery as opposed to the other uses, as I feel this is a more empowering term; however, all uses are found frequently throughout various literatures past and present.

performed 112 cesarean deliveries. This director is cited with stating “once a cesarean always a cesarean,” (Wertz & Wertz, 1989) and this expression is still used today as hallowed fact in many hospitals.

Between 1910 and 1921 in one Boston maternity hospital the rate of operative deliveries increased from 29% to 45% and the trend continued upwards. [A 1933 White House Conference on Child Health and Protection] estimated that three-quarters of the cesarean sections were unnecessary and without them the maternal mortality rate would have been 10% lower. (Tew, 1998, p. 278)

Certainly, few would question that the success and safety of this particular procedure has improved since this time, specifically following the invention of antibiotics (Schram, 2005); however, many raise concern over the justification for its use in the first place. Many have argued that as the procedure became safer it also became an easier intervention – the ultimate intervention – to rely on. In the U.S. the cesarean rate in the 1960s was approximately 3% of all births, in 1970 it was 5.5%, 24% in 1988, and in 2007 the rate was the highest ever reported at 32% (a 53% increase from 1996) (Menacker & Hamilton, 2010; Tew, 1998).

The issue with cesarean deliveries (as with the use of many interventions) has always been assessing the indications for the procedure; there continues to be great debate and discrepancy about the indications and the medical necessity of a cesarean. Medical indications include having had a previous cesarean, failure to progress in labor, fetal distress, breech presentation, and obstructed labor (Block, 2007; Tew, 1998). Most recently tokophobia, defined by Hofberg and Brockington (2000) as an unreasoning dread of childbirth, and maternal request have been added to the list of indications for a cesarean. Assessing, or measuring, the indications for a cesarean remain controversial and appear to be extremely subjective.

In addition to the medical indications for cesarean delivery, many have suggested there may be several social factors that have contributed to the rising rates. Several have argued that cesarean deliveries are easy and more convenient for the doctor to perform. Today, women are also claiming that convenience or fear of delivery influences their choice of cesarean delivery (Karlstrom et al., 2010; Klein, 2005). Studies have shown that the rates of cesarean can vary drastically (19-42%) in the same hospital, simply based on which doctors are on shift (Block, 2007). Another study (cited in Epstein, 2007) indicated that rates increase within close proximity to shift change times (e.g., 4 and 11 p.m.). It has also been noted that cesareans cost about three times as much as a vaginal delivery and wealthier women are more likely to have a cesarean delivery (Baker, 2005). This higher cost implies that there is another benefit doctors and hospitals may gain from a higher cesarean delivery rate and that is financial gain. Finally, medical professionals often cite the rising rates of litigation as explanatory for the current cesarean rate (Reyes, 2007).

The Birth of Twilight Sleep

Women would gladly have given up home delivery, which they valued less anyway, for hospital delivery if it meant the relief of birth pain¹¹. In fact, women themselves campaigned for the acceptance in America of a hospital-based technique for painless birth, developed in Germany and called “Twilight Sleep.” (Wertz & Wertz, 1989, p. 150)

Twilight Sleep, according to Wertz and Wertz (1989), involved giving a woman both morphine and an amnesiac medication through an injection at the beginning of labor. When the actual birth was occurring (second stage of labor when the baby is moving through the birth canal) the doctor would then give a dose of either chloroform or ether rendering the woman unconscious. The doctor would then extract the baby using forceps while the woman

¹¹ Again, consider the circular logic concepts presented in figure 2 on page 25.

was unconscious. Ironically, it has been indicated that a woman's body is capable of expelling a baby, healthily, without intervention even while unconscious. The hormones being released, as well as the muscle constrictions in the woman's body work together to trigger called the authentic expulsion reflex which actually "pushes" the baby out into the world (Roberts, 2006).

Around 1900 a few doctors who had tried the technique of Twilight Sleep had indicated that they felt it was both "unreliable as well as unsafe" (Wertz & Wertz, 1989, p.150). However, some American women were so excited about the prospect of painless birth they went to Germany to deliver and returned to "initiate a newspaper and magazine campaign for American women's liberation from suffering" (Wertz & Wertz, 1989, p. 150). It is interesting that no one seemed to consider that liberation from the hospital itself, and its birth attendants, may have offered the same relief of suffering that woman hoped more medicalization would provide. It can be argued that this is a classic example of an iatrogenic condition. More treatments, or interventions, are required (or requested) to treat the conditions which were created by the original treatment and intervention. Again, it seems necessary to note the way in which society and social perceptions significantly influenced the course of birth in America. Davis-Floyd (1994) would refer to this as the one-two punch of technocracy, in which a naturally successful process is made dysfunctional by technology (punch one) and then fixed by technology (punch two).

Eventually women formed the Twilight Sleep Association and began a campaign for twilight sleep, which was successful and doctors also came to believe the technique was safe (Wertz & Wertz, 1989). In the 1920s the procedure began to be used in Boston hospitals and by 1938 the technique was recommended for use in *all* deliveries. Wertz and Wertz (1989)

noted that twilight sleep “not only attracted women to the hospital, it made them more manageable during labor and delivery and allowed the routine use of other techniques” (p. 152).

The Pregnancy Factory¹²

By the 1940s as maternity hospitals continued to grow in size to accommodate more and more patients, there was a need to organize them in a way to promote efficiency. Spaces (territories) were created based on the tasks that would be performed in them (i.e., labor room, delivery room, recovery room). As a result of this, women in labor had to continually move from one space to another in order that they may find the *benefits* of the particular staff or the equipment located in each space. Patients were moved frequently and found themselves interacting with different, likely unknown, staff persons operating on unfamiliar schedules with each move; each space or staff person had varying agendas and tasks to perform on a specific part of her body or behavior.

This was an industrial-like process - *a machine*.¹³ American culture, along with others, specifically during this era in history, but not unlike today, considered machines and industry as often superior to nature. Although the structure was convenient for the workers, it was not always a comfortable experience for women. This assembly-line process provided women with very little, if any, information about when a procedure would take place, as well as how or why each procedure was occurring – not to mention who would be performing it. Further, some of the psychological influences of these processes were amplified because

¹² A participant in my mini-thesis research (Hardy, 2010) used the expression “pregnancy factory” to describe her feelings about the modern maternity care culture; the expression seemed a fitting heading for this section.

¹³ Recall the admission regimen at Sloane that Wertz and Wertz (1989) reported (see page 31).

there was no option to go through the experience with the support of a friend or family member (Dick-Read, 1944; Klaus & Kennell, 1976; Wagner, 2001).

The Rebirth of Nature

Wertz & Wertz, 1989 stated that “childbirth is not something that you simply let happen to you . . . it is something that you” do (p. 193).

In 1957 a letter from a maternity nurse was printed in the *Ladies Home Journal* in which she “urged an investigation of ‘cruelty in maternity wards.’” The *Journal* received hundreds of letters reporting experiences of dehumanization and unconcern for mother and baby” (as cited by Wertz & Wertz, 1989, p. 170). Several letters noted feeling that procedures were convenient only for the staff but did not account for the patient’s (woman’s) feelings. The letters seemed to summarize the notion that

. . . hospital delivery had become for many a time of alienation – from the body, from family and friends, from the community, and even from life itself A woman was powerless in the experience of birth and unable to find meaning in it, for her participation in it and even her consciousness of it were minimal. (p. 173)

Women began to critically struggle against the industrialized process, which had mechanized birth and devalued – or altogether removed – her personal role, and voice, in the experience.

Women began to demand that birth be an experience in which they could seek self-fulfillment. “They set out to regain possession of their bodies and of the life they had lost” (Wertz & Wertz, 1989, p. 173).

Those who opposed the invasive industrial-like (medicalized) process that birth had become argued that birth was natural and orderly, “a benevolent process rather than a painful, destructive, and possibly catastrophic occurrence” (Wertz & Wertz, 1989, p. 178). The 1960s brought the women’s liberation movement and a time when women desired greater

independence and control over their bodies in general and this translated to birth as well. These desires encouraged women to question the safety of birth as well as to seek improved and empowering experiences in birth. One woman who laid the groundwork for such critique of the maternity culture was the anthropologist Margret Mead.

In 1939, having gained insights about birth while conducting field research in many diverse cultures, Mead argued for – and achieved – an unanaesthetized (conscious) birth in New York. She urged other women to “overcome the ‘male-myth’ of pain in birth” (Mead, 1972, p. 252). She wrote in her autobiography, *Blackberry Winter* (1972), that she had “never heard primitive women describe the pains of childbirth” yet when men were asked to describe what birth was like they were “writhing on the floor in an act of apparent pain and agony” (Mead, p. 254). Mead made clear in her writing that in her experience, it is not women, but rather men, who perpetuate the notion of pain in childbirth – the social implications of this are most certainly significant. Recall, that Rich (1976) wrote the “namers and sayers” – the writers and constructors - throughout history have been men. As such, their interpretations and perceptions have certainly been voiced, and [re]voiced louder than women’s – or rather, women have been silenced as a result.

Others have also echoed Mead’s Trevathan (1993), for example, wrote that “it becomes obvious that childbirth in a contemporary hospital in the United States is quite different from what most human females throughout history have experienced” (p. 337). Tew (1998) wrote that, “for most of human history procreation has been managed by the individuals concerned. . . .birth [is] unaided and without apparent pain or distress. Likewise in different times and place, there have been many records of women, unattended, giving birth simply and safely” (p. 40).

Mead (1972) also provided an example of the role of power and territory and the influence they have on birth. Ultimately, her birth (unanesthetized) was very difficult for her to achieve at the time and she had status, knowledge, and money, which other women did not have.

In 1942 spinal anesthesia became available and was the doctors' answer to recognized dangers of ether and chloroform; women could now have conscious and *painless* birth. These early spinal anesthetics would eventually become the caudal and epidural. Their use became routine in hospitals; however, the use of forceps also remained routine. To give an indication of how widely used and accepted spinal anesthesia has become the national vital statistics system (NVSS), a branch of the CDC reported that in 2008 61% of women who had a vaginal birth (singleton¹⁴) used an epidural. These data are collected from only 27 states. Of the states represented Kentucky had the highest use at 78% of all births, and New Mexico the lowest at 21%, Iowa's rate was 63%. Interestingly, Block (2007) writes that "New Mexico remains the most midwife-friendly state in the nation. In 2004, midwives outnumbered obstetricians. Nearly 1/3 of births were attended by midwives, compared to 8% nationally (p. 179)." Midwives, who are more likely to practice out-of-hospital birth, are consistently cited as using fewer interventions. The NVSS report referred to epidural use as "very common (p. 14)." However, this wide use and the common nature of epidural is not without potential consequence. When the spinal anesthesia is used the women has decreased (or no) feeling in her lower body and thus struggles to be able to push and work with her body's contractions, therefore, often requiring further technological or instrumental assistance to birth.

¹⁴ One baby; does not include women giving birth to multiples.

In 1944 a British doctor named Grantly Dick-Read published his book *Childbirth Without Fear*. He was clearly a man far ahead of the time, for his ideas did not really bolster much attention until decades later during the natural childbirth movement. Although he was no longer alive by the time the natural childbirth movement was occurring, he is often referred to as the father of the movement. It is interesting, or perhaps ironic, that a man is cited as having “fathered” natural birth. Dick-Read (1944) suggested that fear, both from culture and within the individual, was the source of most birth pain and if women could address these fears they would birth without pain. Birth without pain and fear meant birth without intervention, which meant the potential to give birth at home. Many women felt – and still feel today – that the only way to achieve a pain- and intervention-free birth is to stay out of the hospital.

Wertz and Wertz (1989) stated that American medical professionals at first did not offer a positive reception to the natural childbirth movement. One of the key tenets of the women’s liberation movement of the era of the 1960s and beyond was regaining control over one’s own body. According to Wertz and Wertz,

until the 1970s a certain way for a clinic patient to gain the classification of ‘hostile patient’ in a large maternity hospital was to insist upon some form of natural childbirth, as it took too much of the doctor’s and staff’s valuable time” (p. 191).

The movement was referred to as a fad and part of the do-it-yourself craze. Doctors argued that, “It was better to leave the whole process to the doctor and be sure of the result” (p. 191). As a way to address the natural childbirth movement, and the ensuing loss of control for the doctors, the medical profession suggested that natural birth required complete trust and submission to the doctor. The female patient had to recognize and accept that the doctor was

the expert, a caring friend, a guardian of her best interest and the interest of her child, and one who truly desired to ensure her the best experience possible (Danziger, 1989).

However, there were of course benefits of the natural childbirth movement, one of which was that women were now able to have the emotional comfort and support of their partners during delivery. Dick-Read (1944) suggested that the “attendance of one emotionally comforting person throughout the birth was necessary to alleviate anxiety and to humanize the impersonal hospital environment” (p. 83). Interestingly, Wertz and Wertz (1989) noted that “American hospitals were reluctant to admit [husbands] who might disturb routine or worse, compromise the doctor’s authority” (p. 186).

As a result of this movement, doctors eventually began to relent, specifically in their use of forceps, but, they “never gave up episiotomy...cutting and stitching had become so routine by the 1950s that prepared-childbirth literature never questioned its necessity” (Wertz & Wertz, 1989, p. 192). In the 1960s and 1970s empirical psychology and the Pavlovian theory became the foundation for the Lamaze method of prepared-childbirth. However, Wertz and Wertz also noted that even the Lamaze method was still an “improvement upon nature” (p. 193), but also an improvement upon the unconscious births the women of the 1970s knew of from their mothers, so they were willing to accept this implication.

By this time in history American women were so far removed from the concept of midwives attending to labors in homes and the social childbirth era that what was being offered (consciousness) was certainly logical enough to be considered a good enough birth experience. Interestingly, it is this generation of women whose mothers were part of the twilight sleep era, so not only did they willingly accept consciousness as better than what their own mothers, had experienced, but their own mothers may likely have had little

knowledge about birth to share with their daughters. For during the twilight sleep era a large part of the birth story had been lost. What could a woman, who was unconscious for her birth, tell her child about birth? Perhaps something like, “once labor begins go to the hospital and the doctor will take over from there.” It’s not difficult to relate to these daughters then who felt consciousness was certainly better and most women today would likely agree it most certainly was better.

Wertz and Wertz (1989) suggested that doctors came to realize

Childbirth education could be used for the [their] convenience as well as the patient’s.... What was at issue was not the patient’s consciousness or the degree of anesthetization but control of birth. When doctors realized that their control was intact as long as birth was in the hospital, they listened more willingly to requests for “natural childbirth,” for they had the power to define its meaning. (p. 195)

The natural childbirth movement coupled with the women’s liberation movement of the 1960s and 1970s also caused, or rather emphasized, a rift between women. Women who wanted natural childbirth were thought by some to be martyrs for suffering, and those who indicated they did not want natural birth were thought to be detached from their bodies (and selves). Cultural and political issues were certainly ever-present undercurrents of all the arguments regarding birth, as well as religious and family values. These issues are still “hot button” issues in the U.S. maternity culture today.

Ultimately, what the natural childbirth movement called for was women’s autonomy and the humanization (and womanization) of the childbirth experience. Methods like Lamaze and Dick-Read emphasized the role and power the woman had in her own birth, rather than the ability of the doctor. Hospitals, wanting to stay in business, had to respond.

In order to keep natural childbirth patients both happy and in the hospital, doctors were willing to accommodate.

The Future of Birth

At the conclusion of their third edition of *Lying-In: The History of Childbirth in America* Wertz and Wertz (1989) reported that “the consumer’s wish for a more humane set of birth rituals seems to have been fulfilled” (p. 234), while at the same time they also argue that perhaps it has not improved, but rather perceptions and expectations instead have changed. Temporal comparisons may have led women to feel or believe that simply a conscious birth was better than twilight sleep. Therefore, the rest of the medicalization of their experiences seem to come with the territory and are expected and accepted as better than the past and therefore *good enough*. They suggest that the desire for the “perfect, unblemished newborn, free of disease and birth trauma” (p. 234) has become the primary goal of families during birth. In order to achieve this goal women have been willing to “surrender some control over their bodies and some of the aspirations to natural childbirth by choosing to collaborate with medicine’s new birth technologies. They still desire a humane birth experience, but they want a better baby even more” (p. 235). It would seem that few rarely consider that such an outcome, humane birth and a “better” baby, could occur without intervention and medical management at all.

Wertz and Wertz (1989) remarked on the improvements in hospital environments, which over time have been reconfigured, ironically, to appear more home-like and less institutional and industrial. Bedside manner and rapport with patients have become standard lessons in medical schools. Hospitals often offer free child-birth courses and boast family-centered care; however, one wonders if these changes were in the name of humanizing the

birth experience *for* women or based on the need to keep the maternity wards full.

Regardless of the motives, changes have been made and certainly one could argue that the changes have been to the benefit of women.

It is an unfortunate reality that litigation is an integral part of the history of childbirth in America. In fact, it has become more than simply a part of the history; it has become a significant and powerful influence in the story of American birth. Lawsuits and litigation (and preventing them) has been cited by many (Baker, 2005; Davenport, 2010; Lindgren, 2011; Waters, 2011) as a driving force between the increase rates of intervention and specifically cesarean delivery. The cost of malpractice insurance for birth attendants has skyrocketed above other medical professions. The ultimate consequence has been the loss of many general practitioners and midwives who are not able to handle the expense because they are unable or unwilling to take on more clients to offset the increased cost (Baker, 2005; Block, 2007). Being able to see fewer clients allows birth attendants to offer better patient care and increases the likelihood that they will simply be more patient with the birth process itself. Malpractice and litigation have actually driven more women to hospitals and specialists, who, in turn, actually increase their risk of injury or death. At present this socio-cultural-political powerhouse cannot be understated as a major player in the future of birth in this country.

Although rare, there are extreme cases that have occurred in the United States as a result of litigation, including the legal detention of women in the hospital and court orders for surgical procedures (cesarean deliveries) that women refused (Block, 2007; Cahill, 2001; Tew, 1998). Of course, the legal decisions are based on the claim that they are in the best interest of the unborn baby and that the mother's refusal is negligent. Waters (2011) shares

the following story about a case in New Jersey, which involved a woman refusing to sign a consent for cesarean:

On April 16, 2006, V.M., a forty-two-year-old married woman in her thirty-fifth week of pregnancy, voluntarily checked into St. Barnabas Hospital in Livingston, New Jersey.¹ During active labor, V.M. “consented to the administration of intravenous fluids, antibiotics, oxygen, fetal heart rate monitoring, an episiotomy and an epidural anesthetic,” but refused to sign a form consenting to a cesarean section (“c-section”).² V.M. ultimately did not have a c-section, and V.M.’s child, J.M.G., was safely born in “good medical condition” through a vaginal birth.³ However, during a subsequent child welfare determination, V.M.’s “failure to cooperate with medical personnel” during labor and delivery, and specifically “V.M.’s refusal to consent to a c-section factored heavily into [the trial judge’s] decision” that J.M.G. was “an abused and neglected child.”⁴ As a result of this finding, the state removed J.M.G. from her parents’ custody and placed her in the custody [of the state].

Tew (1998) stated, when discussing these legal battles, that, “the mother is to forfeit her right to be protected from physical assault, which is what a surgical treatment for which she withholds her consent actually is” (p. 26). It might be easy to speculate how a woman who finds herself in these scary situations might feel about the experience. Fortunately, at present, these cases have remained rare; however, it is nonetheless concerning that they ever happened – even once might be considered too frequent. Even when circumstances do not go to such extreme measures, asking *how childbirth experiences affect the woman* is a necessary and important question to consider.

Modern Day Birth

Birth by the Numbers¹⁵

At the time that the move from home to hospital was occurring and the use of cesarean procedures was also increasing drastically, maternal mortality actually increased in the United States (Schram, 2005). Tew (1998) wrote in the United States the maternal mortality rate rose “steeply” (p. 276) after 1915 to between 7-9 deaths per 1000 births. Tew reports that at this time the United States had a higher standard of living, greater medical involvement, and a higher rate of mortality than did nations like Great Britain. Great Britain’s rates around the same time (1900-1935) were around 4-5 per 1000 births, which was also an increase from previous years.

In 2005, 4,138,349 births were registered in the United States. This means a change as small as 1% has an impact on approximately 40,000 births each year. There were 18,884 neonatal deaths (death of infant within first four weeks of life) and 1,248,815 cesareans that same year. According to UNICEF’s 2008 data the United States ranks 42nd for neonatal mortality when compared to other industrialized nations. Neonatal mortality is calculated by infant deaths in the first four weeks of life multiplied by 1000 and then divided by live births. Declercq (2009) indicated that critics argue comparisons to small homogeneous nations are not appropriate and therefore this rank cannot be generalized. A second critique is that the neonatal mortality rate is not the best measure and perinatal mortality should instead be used. Perinatal mortality is calculated by taking the number of fetal deaths (28 weeks or more

¹⁵ In 2009 E. R. Declercq, professor of maternal and child health at Boston University’s School of Public Health, released a short video in which he briefly illustrated the picture of birth in America based on “the numbers” (the statistics). The video was titled “Birth by the Numbers” and can be accessed by the public on the internet. In this section I provide a summary of the results he presented, which were calculated based on national public health data.

gestation) plus number of newborns dying under 7 days of life divided by number of live birth plus fetal deaths (28 weeks or more gestation) times 1000. Using only the nations that had over 100,000 births, the perinatal mortality rate in the United States ranks 15 out of 16 nations. When comparing the United States with only 9 other nations, nations that each had at least 300,000 births in a year, we still rank poorly in 8th place.

Next Declercq (2009) discussed the maternal mortality rate, which is calculated by taking all maternal deaths (all causes) and multiplying this by 100,000 and dividing that number by the number of live births. Using data from 2005, the United States was ranked last when compared with other industrialized countries. When compared to just the 15 other nations, which had at least 100,000 births, the U.S. remains in last place. Using the 9 countries, which each had at least 300,000 births, this U.S. again remains in last place when considering maternal mortality. Interestingly, the United States having a “weaker social support system” has been noted as one possible explanation for the higher maternal mortality rate.

Between 2004 and 2005 the United States neonatal mortality improved slightly; however, this improvement was not statistically significant. Declercq (2009) states that what this shows is a “long term trend for no change in the United States.” Worse yet, if we consider that had our rate been similar to some of these comparable nations such a slight improvement would have resulted in 8,000 fewer deaths per year in our country. Recall that those 8,000 fewer deaths are considering if our rate had been *similar* to the comparable nations (which it is not), it does not speculate how many fewer deaths we might have seen had our rate been actually *better* than these nations (which, again, it is not). When considering this slight improvement, a non-statistically significant one, note that the

comparable nations also showed improvement, but these nations started with lower rates and decreased (improved) at a faster rate than did the United States.

Between 2000 and 2005 the maternal mortality rate in the United States actually increased by 54% (more deaths) whereas in the other nations (which had lower rates to begin with) decreased their rates by 16%. Declercq (2009) argued that this represents “not a change in mother; what’s happening is a change in practice” (17:00).

What Declercq (2009), among others (Wagner, 2001; WHO, 2000), demonstrates is that the United States is not fairing well when it comes to birth. As more medicalized management and interventions in birth (often in the name of safety and prevention) are used, the safety of our women and children has not improved and in fact, it has decreased. Despite this evidence it appears that very little is being done at the national level to reverse or improve upon these disturbing trends. Worse yet, according to the 2008 *Listening to Mothers II survey*, few women noted awareness or specifically indicated concern, over the state of birth in this country. Such inconsistencies are most certainly alarming and noteworthy.

According to the Center for Disease Control (CDC), a woman in labor in the average hospital in the United States has a 32%¹⁶ chance of undergoing a cesarean delivery (Menacker & Hamilton, 2010). Interestingly, most medical research suggests that the majority of pregnancies and labors are *normal*¹⁷ usually citing between 5-15% as abnormal, meaning an intervention would be beneficial (World Health Organization, 2007). The World Health Organization (1985a) suggests that only 10-15% of cesareans are needed. Declercq

¹⁶ In 2007 the cesarean rate rose 53% from 1996, reaching 32%, the highest rate ever reported.

¹⁷ In this use, normal simply means without pathology.

(2009) also made note that statistically there appears to be a threshold at which the risks begin outweigh the benefits of the cesarean procedure.

Physiological Childbirth

Wagner (2001) wrote that “Labor and birth are functions of the autonomic nervous system and are therefore out of conscious control” (p. 25). Physiological childbirth is described as initiating spontaneously and concluding with the natural release and delivery of the placenta. An extremely intricate hormonal dance occurs within the woman’s and the baby’s bodies, designed to interact harmoniously during birth. Buckley (2002) stated “the exquisite hormonal orchestration unfolds optimally when birth is undisturbed, enhancing safety for both mother and baby (para. 1)”. Some of these hormones include oxytocin, beta-endorphin, epinephrine, norepinephrine, and prolactin, and are all released to progress labor and delivery and support the infant after birth as well. Buckley (2002) states “four major hormonal systems are active during labor and birth. These involve oxytocin, the hormone of love; endorphins, hormones of pleasure and transcendence; epinephrine and norepinephrine, hormones of excitement; and prolactin, the mothering hormone” (para. 2). The release of the placenta during delivery is what “cues” the breast milk to begin letting down and producing for the infant. Oxytocin, released during both labor and breastfeeding, is a hormone commonly known as the love hormone, as it is the same hormone released during orgasm (Gaskin, 2003).

Additionally, it has been indicated that a vaginal delivery may also offer the baby the benefits of bacteria (specifically the microbes that aid in developing the immune system) present in the mother’s birth canal. Studies have indicated that babies born via cesarean have higher risks of developing asthma, allergies, and other immune-system difficulties.

Domiguez-Bello et al. (2010) report that during birth a baby is exposed to a “wide variety of microbes [bacteria], many of are provided by the mother during and after passage through the birth canal [vagina] (p. 11971).” When a baby is born via cesarean they are not exposed to these same bacteria and this difference can “contribute to variations in normal physiology or to disease predisposition (p. 11971).”

What I aim to point out here is that when labor and birth occur in a spontaneous (not induced or augmented) manner there is a delicate and intrinsic harmonious interaction between various hormones, bacteria, and other physiological functions, which occurs in order to bring the baby into the world. This does not imply that disruption of these interactions (e.g., interventions) may not, at times, be necessary. I will not speculate as to the indications for such necessity here. The intention here is simply to briefly offer you, dear reader, a picture of the physiological process of childbirth as best understood at present. It is crucial to be aware of the way in which these processes interact and influence one another to the potential benefit of both mother and baby and the impact to the mother and baby when the process is varied.

The Effects of Childbirth

The Woman – The Mother

The moment a child is born, the mother is also born. She never existed before. The woman existed, but the mother, never. A mother is something absolutely new (Rajneesh).

Birth is not only about making babies. Birth is also about making mothers – strong, competent, capable mothers who trust themselves and know their inner strength (Barbra Katz Rothman).

In the following section I will address the way in which childbirth experiences influence women – mothers. I want to highlight the individual nature of these experiences

and never to assume that one experience is like any other; however, for the purposes of this section I may speak in broad generalities. Additionally, I want to note my use of the word woman and mother, as I often will use them together. I do this with intention to draw the reader to the importance of the role that the woman plays; she is an individual woman, yes, but also a mother, interacting with, caring for, and guiding the life of her child. I find that in the context of this feminist critique and specifically in this section it is necessary to emphasize the duality and inter-related nature of these two roles. Furthermore, following this section I will address the influence of childbirth on the child particularly from a socialization standpoint, considering the mother's role in the child's development process. I want to note that this section is critical in nature, and therefore, throughout the following text I integrate rhetorical questions. These serve as a guide in the research process, but also a point of reflection and consideration for the reader.

In various cultures, mothers and their new babies are honored with ritual celebrations. This helps mothers adjust to their new status. In American culture, however, childbirth as a rite of passage is downplayed. . . In American culture, giving birth becomes fragmented into medical timetables and routines, a framework that may have little to do with a birthing woman's deeper sense of the transformation she is experiencing. Childbirth ritual in the United States is hospital ritual. (Eakins, 1986, p. 99)

The birth of a child means many things to many people. Certainly, with the birth of a first child specifically, it is a time of transition to the new role of mother. Some refer to this time of childbearing and transition as a rite of passage. From a sociological perspective, birth may be viewed quite simply as the resulting addition of a new social member to society. Few would question that childbirth is foremost profoundly emotional and ultimately a life altering experience for any woman. But what does this mean? How do women make meaning and integrate their experiences with birth into their lived experiences? What are the

messages and experiences from their tenure in the maternity culture that women internalize, and to what end? In many ways it may seem obvious or redundant to state that birth is emotional and life altering, but to each individual woman and mother, this experience impacts her life in diverse ways based on her ascribed meanings and her perceptions of the experience.

How a woman perceives her childbirth experience can influence her overall feeling of satisfaction, competency, and psychosocial well-being. Several studies have indicated that lack of support and the use of medical interventions can lead to women reporting less satisfaction with their birth experiences (Melender, 2002). Clearly there could be much debate about what constitutes a satisfying birth experience and this has been explored in the research. Gamble, Greedy and Moyle (2004) reported, “a distressing birth experience can produce debilitating symptoms of psychological trauma” (p. 116). Does a satisfying birth experience simply mean a healthy child - and a healthy mother? And which elements of health are being considered with this assumption? Is it satisfactory to have experienced a “short” and “easy” birth – and whose measure of time and ease shall we use? Although some research has explored the notion of satisfaction with birth, ultimately what it appears to come down to is the individual woman’s perception of her experiences – not any external judgment or standard. If the woman perceived a positive experience, then this is what she had and vice versa.

Women who report more fear prior to birth have increased risk for increased intervention, but also for post-partum depression (PPD) and post-traumatic stress disorder (PTSD) (Fisher, Hauck, & Fenwick, 2006; Melender, 2002). However, even women who reported limited fear, or rather typical levels, are more likely to experience PPD or PTSD if

they perceived their experiences to be psychologically traumatic or difficult. Beyond specific clinical diagnoses like PPD or PTSD, Axness (2007) addressed the joy a mother feels about herself, her new baby, and her new role as mother as a key element in understanding psychological well-being following childbirth. What factors influence these feelings and outcomes for a woman? It has been suggested that the modern American birth experiences are disembodied for women (Davis-Floyd, 1994). Davis-Floyd (1994) suggests that through the medicalization of childbirth, women have been reduced to simply being vessels, carriers of the infant, a product of medicine, rather than holistic emotional beings. Wagner (2001) wrote a paper entitled “Fish can’t see the water: The need to humanize birth,” in which he said, “Humanizing birth means understanding that the woman giving birth is a human being, not a machine and not just a container for making babies” (p. 25). Do American women feel separated from their bodies, and if so, what does this mean? Others, like Simkin (2006) have also critiqued the maternity care system and government regulatory boards, for limiting the choices (and voices) of women. Simkin argued that women are being convinced by these organizations (hospitals, governing bodies, and social media) that they have many choices in their care and in the outcome of their experiences when in fact their choices are limited and few. Are women aware of the influence of these organizations on their individual choices, and if so, what does this mean to them and their meaning-making from their experiences?

Two elements, (a) recognizing childbirth as an emotional and life altering experience and (b) support and intervention issues, can influence feelings about childbirth experiences and these two elements lead me to ask several questions:

- How does the modern maternity culture in America view and value the emotional components of childbirth experience for the individual woman?
- What does it mean for the woman, the mother, when she feels less satisfied with her birth?
- What are women's individual experiences within the maternity culture? How do women feel their satisfaction was influenced by these experiences?

Pregnancy and childbirth experiences can influence a woman's well-being, both physically and psychologically, and therefore can influence how she is able to parent her newborn (Bayes, Fenwick, & Hauck, 2008; Edhborg, Matthises, Lundh, & Windstrom, 2005; Emerson, 1998). Fisher, Hauck, and Fenwick (2006) indicated that pregnancy and childbirth experiences will inevitably influence "a woman's physical and emotional well-being" (p. 65) and the power of these experiences has long-term implications for both mother and infant (Emerson, 1998). Olde, van der Hart, Kleber, and van Son (2006) suggested that childbirth is experienced in an "emotionally intense" (p. 1) manner. Negative and traumatic experiences during pregnancy and childbirth have been linked to higher rates of post-partum depression (PPD) and even posttraumatic stress disorder (PTSD) and may be detrimental to maternal-child relationship (Melender, 2002; Olde et al., 2006; Sorenson & Tschetter; 2009).

Barr (2006) noted that mothers who suffered from PPD displayed "a delay in becoming competent in parenting skills" and displayed a "lack of maternal-infant attachment" (p. 362). Barr also noted that mothers with PPD cared for their infants in an "unthinking manner that was labeled 'mechanical infant caring'" (p. 362). McMahon, Barnett, Kowalenko, and Tennant (2006) reported that depression in mothers can have a negative impact on the mother-infant attachment relationship and that infants of depressed

mothers were more likely to be insecurely attached. Mothers with higher levels of depressive symptoms tended to have less warmth and responsiveness in their parenting strategies.

As we have seen so far, inherent in the symbolic framework of the medicalized world view of pregnancy is a power relationship. Medical professionals, through ownership and exclusive control of highly valued specialized knowledge, acquire the ability to manipulate the situation [woman]. The patient may then feel like an outsider, alienated from her own experience. (Eakins, 1986, p. 101)

Medical interventions, regardless of their necessity, have been linked to increased risk of PDD and PTSD, apathy towards parenting, lack of emotional connectedness to infant, and feelings of inadequacy (Axness, 2007; Olde et al., 2006). The rising rates of medical interventions have been noted repeatedly as a global concern. Approximately 41% of all labors are induced (Knoche, Selzer, & Smolly, 2008) and on average around 30% of all births are delivered via surgery (cesarean).

Interventions during labor can decrease a woman's sense of autonomy, which can influence long-term psychological outcomes for both the mother and child (Baker, 2005; Sorenson & Tschetter; 2009). Sakala (2006) reported that many of the commonly used interventions "lack scientific support" and have "multiple adverse effects" (p. 246). These adverse effects then lead to the use of more interventions to "prevent and treat these harms" (p. 246) created by the first intervention – an iatrogenic condition. Interestingly Sakala suggested that "this [maternity care] system failure is presented and appears to women as routine failure of their own bodies ('inadequate pelvis,' 'failure to progress,' 'failed induction,' etc.)" (p. 246). This interaction between a woman and the medical professionals can have a significant emotional impact on the laboring mother. Olde et al. (2006) cited "negative aspects of staff-mother contact" and "feelings of loss of control over the situation" (p. 1) as two risk factors for the development of PTSD following childbirth.

Showing women. . . that they are inferior and inadequate by taking away their power to give birth is a tragedy for all society. . . . Respecting the woman as an important and valuable human being and making certain that the woman's experience while giving birth is fulfilling and empowering is not just a nice extra, it is absolutely essential as it make the woman strong and therefore makes society strong. (Wagner, 2001, p. 25)

A successful pregnancy and birth that results in a healthy infant is the primary focus and concern of childbirth professionals – a concern mothers share as well; however, the importance of nurturing and supporting women's mental health during pregnancy and childbirth is beginning to be recognized as an important concern as well (Fisher et al., 2006). The infant-outcome system has been criticized for its preventative stance, which implies that most women and infants are “at risk” and overstating the necessity of intervention in the name of prevention (Baker, 2005; Block, 2007; Tew, 1998), when in fact, in most pregnancies the infants would be born healthy without intervention. Evidence suggests that most pregnancies are low risk and fit under a normally distributed statistical curve, indicating that the average pregnancy on this distribution (the vast majority) would result in a healthy baby. However, the medicalized-model shifts focus away from normalcy and implies (and intervenes) based on the pretense that women and their infants are at risk and require the life-saving technology and intervention of the medical professionals (Darra, 2009; Searle, 1996; Tew, 1998).

There appears to be another potential issue, or factor, which is best discussed in the context of this discussion and that, is apathy. One participant in my mini-thesis research (Hardy, 2010) shared a potential relevant example, one worthy to note and reflect on at the very least. This participant (Heidi) shared that since she never held any belief or notion that she would be in control of her birth (also having been influenced by experiencing infertility)

she felt little loss of control or power-struggles. Heidi stated that she never believed the power or control to have been hers in the first place. She placed her trust 100% in her doctor and she believed doing so reduced any negative feelings about who was “in charge” of her birth and the experiences she had.

Fisher et al. (2006) reported that childbirth “should be a positive and life-affirming event associated with minimal risk of an adverse outcome” yet instead there is a “high prevalence of fear” (p. 64). Fear is associated with an increase in complications during pregnancy, higher rates of interventions, emergency and elective cesarean births, PDD, PTSD, and “impaired maternal-infant connection” (p. 65). These individual outcomes for a woman have influences on her “role as a mother and interpersonal parental relationships” (p. 65). Hofberg and Ward (2003) suggested that maternal mental-health is an important factor during childbirth and in the early post-natal period. How a woman reflects on her birth experiences has implications for psychological outcomes and family functioning. Fisher et al. (2006) suggested that “nurturing and supporting women’s mental health during pregnancy and childbirth is important in ensuring long term psychological and social well-being of women, their babies and families” (p. 74).

Parenting a newborn can be a challenge and emotional preparedness for facing these challenges can positively influence child development. Axness (2007) addressed the issue of attachment and brain development in children and suggested that through eye contact and the mother “gazing” at the infant, a child “discovers who he (sic) is, and wires up his (sic) brain to match” (p. 317). In essence, if a mother gazes at her child with love, a child will internalize that s/he is loved. Swain et al. (2008) studied brain responsiveness in women in the immediate post partum period (1-3 days following delivery) and reported that women

who delivered vaginally were “more sensitive to their own baby’s cry than mothers who had delivered via cesarean” (p. 1042). What this pilot study demonstrated is that at a neurological level, birth experiences can impact a woman and mother, specifically in her responsiveness to her infant’s crying. Finally, separation between mother and child following birth can “interrupt the biologically-mandated postpartum connection between mother and baby, which needs to be recognized as an essential protective factor against PPD” (Axness, 2007, p. 318). Simply put, what Axness argues here is that a mother cannot lovingly gaze, or bond, with her infant when the two are separated.

The Child

An easier birth, involving less shock upon entering the world, can be expected to build less fear into the unconscious of the growing child, who may then be able to face frustrating experiences later in life with greater emotional control. (Freud, 1938 in Thomas, 2005, p. 62)

According to Thomas (2005) Sigmund Freud reportedly believed birth to be “the first great shock” (p. 62) and therefore considered it a highly significant event in a child’s life. Freud argued that “the birth trauma, then, is the prototype of all subsequent fear-producing situations children will meet as they grow to old age” (p. 62). What impact do the first moments of life have on an individual? What does the child experience when those moments are filled with chaos, panic, and fear? How does the child experience and interact with a parent who is feeling disempowered, disembodied, or defeated in the early days and weeks of its life? How does a parent’s feeling of loss, sadness, or confusion reflect back to the child and become embodied in the child’s own sense of self?

Attachment. Attachment theory is the result of collaboration between John Bowlby and Mary Ainsworth (1991). Attachment in brief summary is the concept of the nature of

child's experiences with the caregiver (often the mother) and the security and trust the child has regarding these experiences. It is about a relationship between the two players, the infant and the caregiver. Infants develop a sense of trust when caregivers sensitively meet their needs. The caregiver's sensitivity and warmth in responding to the infant's needs contribute to the level of trust the infant will have in the relationship. Ainsworth (1978) described the basic patterns of attachment (which represent the level and nature of trust and security in the relationship) as: (a) securely attached, (b) avoidant attached, or (c) resistant/ambivalently attached.

Studies have indicated that these attachment patterns, which are formed in infancy, persist (Karen, 1994). Ainsworth was clear that a responsive caregiver (mother) was necessary to provide a secure base, from which a child would be more likely to develop a secure attachment. This base, along with the caregivers' availability, also allows the child to be able to explore his or her environment (a key to brain development). Ainsworth was adamant that warm, sensitive, and responsive care does not create a dependent child but rather liberates the child and promotes autonomy (Ainsworth, 1969; 1978). Bowlby (1990) believed that an infant will develop an "internal working model," which he described as the infant's sense of self or self-concept. Miller (2009) comically described this internal model as "swallowing our parents," in the sense that an infant will internalize (swallow) the concepts of worth which are presented to them by their caregiver. Ultimately, what this adds up to is concern then for what messages the child is receiving when interacting with care providers. Does the child feel valued, wanted, loved?

In a Canadian joint policy statement on normal childbirth four factors have been cited as key in creating a positive environment for healthy infant brain development: (a) healthy

attachment, (b) responsive care, (c) breastfeeding/breast milk, and (d) protection from harm (Canadian Child Care Federation, 2001). The United States Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) did not endorse this position statement which was developed with input from the Canadian AWHONN. All infants provide cues and signals to their care providers regarding their needs. The responsive care provider is one who learns to read, anticipate, and respond to the cues and signals in a sensitive, warm and accepting fashion (Benoit, 2002). Perry (2001) suggested that a healthy attachment process is a two-way experience between caregiver and infant, which lays the ground work for all future relationship development. Miller (2009) reminded us that at the very core of healthy attachment develop is the issue of trust. Through consistently, responsively, and appropriately meeting the needs of the infant, the infant is then able to develop a sense of trust in the care provider and this trust carries over into other relationships throughout life.

What messages does a mother who may be feeling "less than" reflect to her child when gazing into his/her eyes? Studies have indicated that positive perceptions of both pregnancy and childbirth experiences are predictive of increased secure maternal attachment and competence (Mercer, 1986). Bryanton, et al. (2009) reported that "a negative or traumatic birth experience can lead to a sense of failure and inadequacy and problems with maternal/infant attachment" (p. 192). Additionally, Bryanton et al. (2009) reported that having a vaginal birth was predictive of more positive parenting behaviors at one month postpartum.

Several other childbirth related factors have also been explored as influential factors for parenting behaviors and attachment. Two of these factors, which are relevant to the

previous discussions presented in this paper, include social support and early maternal-infant contact (Mercer & Ferketich, 1994; Minde & Hesse, 1996).

Moburg (1981) explored the relationship between mothers' reports about their perceived quality of their childbirth experiences and patterns of attachment; 43 participants reported on their experiences and were placed in high, low, and undetermined quality experience groups at one month postpartum. The infants in each of the groups were observed in their homes at 6, 8, and 10 months of age. The study indicated "the quality of the birth experience seems to be related to the quantity and affective tone of the mother-infant interactions. High quality birth pairs interact significantly more and smile more; the mothers are more affectionate than low quality mothers" (p. 134).

Lilienthal (1983) examined the psychological aspects of cesarean delivery. She studied 46 intact middle-class families, divided into two groups based on method of delivery (vaginal or cesarean). Lilienthal found that "cesarean birth was related to a higher incidence of depressed affect among mothers. . . [and] infants born by cesarean under optimal conditions to socio-economically advantaged parents may be at greater risk for the development of an anxious attachment" (p.103).

In summary, this review of literature indicates a potential relationship between childbirth experiences and mother-child attachment based on either perception or experiences of the mother. However, some would argue that a traumatic birth, regardless of the mother's perception of the experience, is in and of itself capable of influencing child development. As Oliver (2004) suggested, "All attachment begins in the womb" (p. 169) and Freud believed birth is the first trauma in life. Regardless of whether any, all, or none of these factors (mother's perceptions and affect following birth, method of delivery, or traumatic birth

experiences) are influential on a child's development, it seems clear that further investigation is warranted when considering the effects of birth on the child.

CHAPTER 3 METHODOLOGY

The purpose of this study was to explore how woman feel about their childbirth experiences and most significantly, how do they feel about themselves following their journey through the maternity culture in America. More specifically, I used a qualitative methodology to gain a greater understanding of the role of socio-cultural, historical, and political trends on the context of American childbirth experiences. The guiding research questions for this study were as follows: (a) What are the childbirth experiences of American women, specifically those which relate to disenfranchisement? (b) How do women make meaning of their childbirth experiences? (c) How do women navigate and interpret the maternity care culture in the United States?, and (d) What roles do socio-political and historical contexts play in individual experiences? There were additionally three primary goals for this research project. These goals are as follows: to explore (1) the socio-political, cultural and historical influences that spurred changes in childbirth in America; (2) the claims of safer birth; and (3) the ways in which women understand and feel influenced by these factors (changes over time and safety claims).

Methodology and Theoretical Perspective

Both feminist and ethnography methodologies and techniques were employed throughout this research project to address the research questions and goals. This is a feminist piece of research, based on the notion that this project is hoped to be *for* women, not simply *about* women (Bloom, 1998). Additionally, it is also feminist as women's experiences within a culture/system are a key feature of the project (Prasad, 2005). Examining and uncovering hegemony (Madison, 2005) and the marginalization or

oppression of women (Prasad, 2005) during their maternity experiences was also the primary focus of this project. Researchers with a feminist perspective have as an underlying goal that readers of their research reports will hear the voices of the participants and as a result, will feel a shift in their understanding and will answer that shift with renewed action, often political, related to the cause or issue under study.

This project was also ethnographic, as a specific culture or subculture was the focus of study (Creswell, 1998). In this case, women's maternity experiences, embedded specifically within the American maternity culture, were the primary subculture of exploration. This research was also ethnographic based on the level and depth of immersion within the maternity care culture to which I, as researcher, was embedded (Madison, 2005). In many ways this project had to be ethnographic, as I find that I cannot remove myself from the maternity culture – in several ways. First, I have given birth in the U.S. Second, I am of a childbearing age, meaning although I may not be a consumer of the maternity culture at present I am often surrounded by peers who are – and women talk about childbearing! Thirdly, I work as a professional within the maternity culture, providing support and education. My personal experiences have embedded me within the maternity culture and my research interests have brought me even deeper into that culture.

Participants

Participants for this study came from two groups (a) women who have given birth over the past four decades (1970-2010, approximately two generations), who are referred to as “women” (and this group is later subdivided; see below) and (b) professionals who provided care to women during their maternity period during this same time frame (1970-2010) who are referred to as “professionals.”

There were a total of 17 participants in this study; I will describe them in the remainder of this dissertation as three groups. Group 1 (the women group) consisted of eight women who gave birth between 1997 and 2010. Group 2 (professionals group) was four professionals who each have provided a service to women during pregnancy, childbirth, and the early post-partum period in the last 34 years. This group consisted of one obstetrician (OB) in practice for 19 years, one labor and delivery nurse who is also a certified childbirth educator in practice for 34 years, and two certified nurse midwives (CNM) – one attending in-hospital births (for eighteen years) and the other out-of-hospital births (for nine years). Group 3 (cohort women group) is five women who meet the criteria for “women” (having given birth) but with each having given birth for the first time in a different and earlier decade than the women group consisting of eight women; the cohort women group consisted of two who gave birth in the 1970s, two who gave birth in the 1980s, and one who gave birth the 1990s. Since one of the eight women in group 1 gave birth in 1997 her information was used as the second woman to represent the 1990s cohort, rather than seek another participant. The cohort group of participants was sought to address the research goal of exploring changes in childbirth over the past few decades and thus in actuality are a subset of the part of my participants who I labeled as “women.” A summary of this information is provided in Table 1.

Women were not excluded based on the number of pregnancies and births they have experienced; however, the primary focus of discussion was on their first successful pregnancy and birth. Women who experienced a pregnancy or birth that included infant mortality, which included late-term miscarriage or stillbirth as well as death within the first 28 days of life, were not included because of the likelihood that the experience would have

Table 1
All Women Participants with Information Related to First Birth

Participant	Year of 1st Birth	Provider	Location of Birth	Type of Delivery	Interventions
Women Group (n=8)					
Eleanor	2006	CNM	Home	Vaginal	Pitocin (post-partum)
Isabella	2008	OB	Hospital	Vaginal	Epidural, forceps
Judy	1997*	OB	Hospital	Cesarean	Epidural
Cassandra	2009	OB	Hospital	Cesarean	Induction, Pitocin, Epidural
Layla	2007	OB	Hospital	Vaginal	Induction, Pitocin, Epidural
Emma	2008	CNM	Hospital	Vaginal	Induction, Pitocin, Epidural
Molly	2007	OB	Hospital	Cesarean	Induction, Pitocin, Epidural
Lily	2010	CNM	Hospital	Vaginal	None
Cohort Group (n=5)					
1	1976	General Practitioner	Hospital	Vaginal	Spinal Block
2	1974	Obstetrician	Hospital	Cesarean	General Anesthesia
3	1985	General Practitioner	Hospital	Vaginal	None
4	1987	General Practitioner	Hospital	Vaginal	Nubain
5	1993	General Practitioner	Hospital	Vaginal	Induction, Pitocin, Epidural

*Judy's 1997 birth was used as the second birth in the 1990 cohort. This ensured that each decade cohort was represented by two births.

significantly influenced their perceptions and experiences during subsequent childbirths. Women who experienced early (first trimester) miscarriage were included as potential participants since previous literature suggests that although these early miscarriage experiences may influence women's fear during early pregnancy, these women typically report childbirth experiences within the maternity culture that are similar to those of women who did not experience early miscarriage (Hjelmstedt, Widstrom, & Collins, 2006). The women (not including the subset group representing the cohorts) at the time of their first birth ranged from 19- to 33-years of age. Women who participated in this study were both single and married, and both African-American and Caucasian. Various education levels and professions were represented in the women participants. Additionally, geographic locations other than the Midwest were represented.

Participants were recruited purposefully and via a snowball method. A recruitment flyer (see Appendix A) was created to briefly explain the project and type of participants sought. This flyer was distributed via email, in mailed letters, and in person to various personal, professional, and academic contacts. Additionally the flyer was hung in several examination rooms at a local medical clinic for exposure to a significant number of women. I also wrote a letter (see Appendix B) specifically seeking professional participants (n=4, see table 2) and mailed it to providers of maternity care. The flyer was included when I mailed the letter as well as a research summary (see Appendix C). The research summary was also the document I provided to potential participants when they contacted me and requested more information.

Table 2
Professional Participants with Information Related to Participants' Profession

Participant	Years in Profession	Profession
Paige	9*	Certified Nurse Midwife (CNM) (out-of-hospital)
Jessica	33	Labor and Delivery Nurse, Certified CB Educator
Penelope	18	Certified Nurse Midwife (CNM) (in-hospital)
Dr. Steven Reid	19	Obstetrician

*Additionally, a labor and delivery nurse for 10 years prior to becoming a midwife.

Procedures

Data collection. Data were collected primarily using interviews. However, some literary artifacts (n = 5) (pamphlets, clinic literature, and brochures) were also collected for the historical piece. Additionally, observations were made and field notes were created during interviews. Appendix D shows an interview summary form that I used as one means of creating field notes.

Feminist research methods challenge the dominant hierarchical notions of researcher-researched (Bloom, 1998). Therefore, interviews were conducted in a conversational tone¹⁸ in a friendly open-ended manner (Bloom, 1998). The intention of my conversations with women was to capture each woman's unique birthing stories and lived experiences; with professionals the intention of my conversations was to gain an understanding of their perception of women's experiences and their role in those experiences.

Grand tour (Glesne, 2006) questions were created (see Appendix E for a full list of questions) and served as a starting point for interviews with both the women and

¹⁸ I will use the terms conversation and interview interchangeably within the context of this paper.

professionals. I began each interview with the women with a SQUIN (Wengraf, 2001) – single question aimed at inducing narratives – which was “Tell me your birth story;”; however, I typically began my interviews with the professionals by asking them to describe what they do and I focused on the current “climate” of the maternity culture and how, if at all, they have seen the climate change over their tenure in the profession. Probing questions to gain clarity and deepen understanding emerged during interviews when necessary; however, some probes or specific prompt questions were also prepared in advance and used during interviews (see Appendix E) (Bloomberg & Volpe, 2008).

Conversations with professionals typically proceeded along a somewhat more defined pathway of questioning, since the purpose of the information I was seeking from the professionals was to obtain data about their support giving to women during childbirth. The data from the professionals served to “support,” enhance, and shed further light on the data obtained from the women themselves. Thus, the information I sought was specifically about their experiences as they support, help, and/or attend to women in women’s childbirth experiences.

Interviews with both the women and professionals were arranged at locations the participant chose as convenient and comfortable for them. On average each conversation lasted approximately one hour. I did not schedule formal follow-up interviews with any participant; however, I did maintain email contact with participants and provided at least one update to each of them about the progress and state of the research and informed them they could share with me any thoughts or concerns at that time. One participant did send an email in response to this follow-up and shared some information that she had thought about and

reflected on following our interview. I considered this email as part of her “data file” and took it into account with the rest of the analysis.

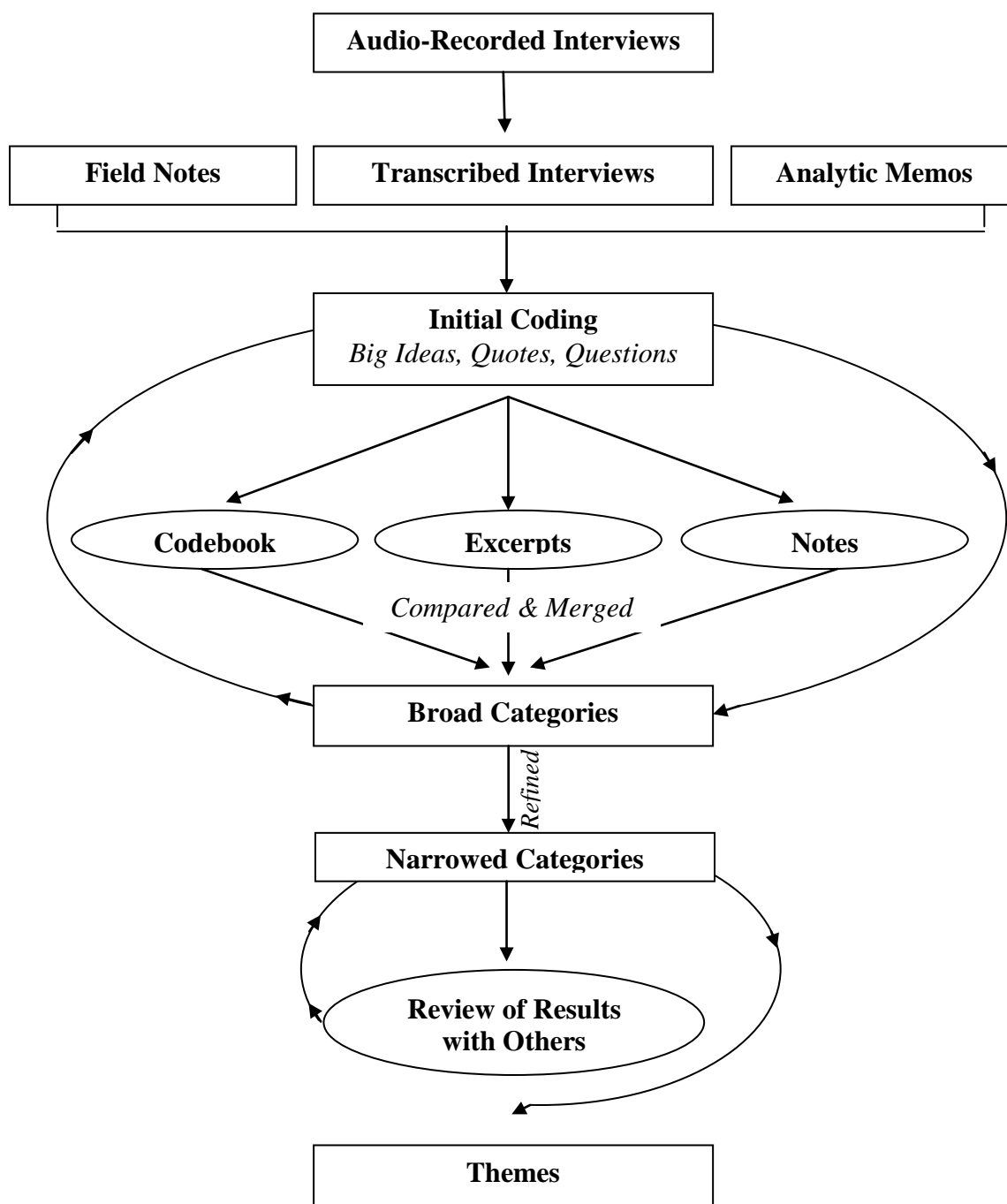
Data analysis. Throughout this research process I was looking at, thinking about, and conceptualizing the data. This means that I allowed the data to shape the project as it progressed. In addition to the constant interaction with the data, during the analysis phase I followed some specific steps which are represented in Figure 3. I have elaborated on each of those steps below.

The first step involved taking notes during transcription (see Appendix F). While I was listening and transcribing I would also work on the transcription notes sheet as a means to begin coding, select poignant quotes, and create analytic memos. I also added to the transcription notes sheet I had created for each participant while I was reading over the complete transcripts.¹⁹

The second step involved identifying “big ideas” during initial coding, which primarily relied on in vivo codes. According to Saldana (2010) in vivo codes are “taken directly from what the participant himself (sic) says” (p. 3). During the first round of coding and note taking I was also pulling excerpts from each transcript and combining them to create two new documents (one from the professionals group and one from the women group) shown in Appendix H. During this first round of coding, as with the interviews themselves, I used constant comparison methods. I also created a codebook (see Appendix I) with approximately 250 of these initial codes following this first round of coding. When creating the codebook I did not edit for content or duplication of a code or concept; I intentionally wanted certain duplications (from multiple transcripts) to appear and also others

¹⁹ See Appendix G for an example of how the transcription notes form (Appendix F) was used.

Figure 3
Graphic Representation of Data Analysis Steps



that might easily collapse. This was one visual way (repetition) that I was able to both see and recognize that saturation was being reached in the data and also that a represented code could be easily formed into a category. Following these first two steps I now had (a) notes (field notes, memos, and transcription notes), (b) the excerpts documents, and (c) the codebook.

The third step was to review, compare, and merge these documents (notes, excerpts, and codebook) into a new document, which constituted my initial broad categories. After this first comparison and merger, I had created 37 broad categories (see Appendix J). I then reviewed these broad categories and found that simply by reviewing the ideas represented, some of them could easily be refined, narrowed, or combined; following this reduction I then had 27 broad categories. For each broad category I wrote a brief (2-3 paragraphs) description of the category (see Appendix K). I did this to help with my own understanding of how or why I had come to construct the category, but also as a preliminary means (analytic memo) of beginning to write up results as they were being constructed. I used my notes, experiences, and direct participant quotes to help build these brief descriptions.

The fourth step was then to [re]apply the 27 categories I had constructed back again to the original documents (whole transcripts, field notes, memos, and other documents). I printed a sheet with my categories on it and re-read each transcript, excerpt page, note, and memo and [re]applied (re-coded) using only the categories on the sheet. I would write a question mark on lines that I felt might be significant but for which there seemed to be no appropriate category. I also took notes, directly on my categories sheet during this process, specifically regarding any category that I felt might not be represented on the sheet, but which I felt might need to be considered as a category. I then took my categories sheet and

flipped through each sheet of excerpts only, rather than each document I had re-coded, and created a tally mark (the actual sheet is shown in Appendix L) under each category when it was noted (coded) from the data. This created a visual representation of how often a category was being represented (supported) in the data. I then reviewed this category sheet again and was able to determine that other categories could be narrowed and reduced (by combining them) with others. As well, I was able to see (by the tally marks) quite easily which categories were being represented over others. Next seven narrowed categories were constructed based on their dominance in the data and an eighth one based on its *lack* of representation. This eighth category I refer to as an “un-finding,” as it was constructed based on its absence in the data. I felt that the lack of representativeness in the data was significant and worth noting in the preliminary results. Appendix M contains a table showing how the 27 broad categories were reduced, refined, and combined to 8.

The fifth step in data analysis was to create a preliminary results document, which could be reviewed by peers and participants as well as others.²⁰ I used the descriptions I had already created and went about elaborating, adding more quotations from participants, and combining and editing when and where it seemed necessary. I also added the un-finding and two introductory paragraphs intended to help the reviewers understand what it was they were going to be reading (see Appendix N for a copy of that document, which I sent out for review). This document was referred to as the “preliminary results” for this study. I then created an instructions and feedback form to assist reviewers in understanding the data they were viewing and also to ask for specific feedback regarding their reading (see Appendix O).

²⁰ Because I had peers, participants, and other non-participants review my results, I do not refer to this process as a member check, because others (besides members) participated in the review. However, this process is essentially the same as what is commonly referred to as a member check in qualitative research.

Nine of 12 participants (women and professional groups) as well as 5 of 5 academic peers, and 3 nonparticipants provided feedback regarding the results. It was important to me to engage with participants at this point in the analysis process, rather than at the beginning (when I had only transcripts) because at this point, I was constructing meaning and understanding. It was necessary that the information I would be reporting was representative of their experiences.

I used the information provided in this review process described above and moved to the sixth and final step in my analysis: refining, narrowing, and drawing final conclusions – creating themes. Although feedback was positive overall and there was interest in the un-finding, it seemed more appropriate that this finding, based on lack of representation in the data, be included for discussion purposes, but not developed further into one of the final themes. Choosing to not develop this un-finding into one of the final themes left seven categories, which were developed into a final seven themes. However, later, after one final round of reviews, analysis, and discussion with colleagues an additional theme, replacing, but not in place of the “un-finding,” was later determined to be appropriate and necessary to include based on reviews of data with my co-major professors. This theme was titled, “Asking questions and advocating.”

Observation analysis. “Detailed description means that authors describe what they see. . . . within the context of the setting of the person, place, or event” (Creswell, 1998, p. 144). During interviews and interactions with participants, descriptive and reflective field notes (Creswell, 1998) were recorded in both written and audio format (see Appendix D). These served as one means to provide background information and context-rich details of current maternity experiences, the participants themselves, and their lives. My goal as an

ethnographer for this research was to write in a descriptive manner, which creates visual images and a sense of “being-there” for the reader (Creswell, 1998). Analysis from observational data also provided evidence and support for codes and categories as they were constructed (also referred to above as “notes and/or memos”).

Document analysis. The primary means of document analysis for this project included the review of historical documents and texts which were presented (briefly) in the review of literature. Some of this historical literature will also be embedded with the results section to help highlight (and address) the research questions which related to the role and influence of historical context.

Charmaz (2006) indicated that

All qualitative research entails analyzing texts; however, some researchers study text that...they obtain from other sources....Extant texts consist of varied documents that the researcher had no hand in shaping. Researchers treat extant texts as data to address their research questions although these texts were produced for other, often very different, purposes. (p. 35)

Therefore, other documents that were collected (e.g., flyers and brochures, pamphlets, medical literature) were analyzed in the same method I used to transcribe interviews or other memos and texts (i.e., seeking themes/unified understandings).

Quality and Rigor

Lincoln and Guba (1985) offered four criteria to assess the quality of a study: (a) credibility, (b) dependability, (c) transferability, and (d) confirmability. I addressed each of these criteria in various ways discussed in the following sections.

Credibility. The credibility of a study may be understood as the believability of the findings. Bloomberg and Volpe (2008) stated that “this criterion refers to whether the participants’ perceptions match up with the researcher’s portrayal of them” (p. 77). Member

checks²¹ with each participant, both women and professionals, were of significant importance to the trustworthiness of this research. I sought member checks from as many of the participants as possible who were willing to engage in the ongoing process of the research. I provided all participants (professional and women groups), via email, with the preliminary results (eight categories, see appendix N) of my findings, presented in part two of the results section, as a member check (Bloomberg & Volpe, 2008; Guba & Lincoln, 1998; Lincoln & Guba, 1985). I provided instructions and a feedback form for participants to complete if they did choose to engage in the optional review of results (see Appendix O). Nine participants provided feedback, which was considered in the final refining of categories and analysis of data. Additionally, I provided each woman (group 1 only) with my [re]telling of her birth story, presented in part one of the results section. I requested that she read the story and inform me of any changes, thoughts, or concerns she might have regarding the [re]telling of her own story. A copy of the email explaining this is located in Appendix P. Six women responded and I revised their individual stories as needed in collaboration with them. I also provided each professional with their summarization of my [re]telling of their thoughts and experiences. Two professionals responded and I revised their stories as needed in collaboration with them.

In addition to providing participants with the results of the study I also engaged in several meetings with peers to review data and discuss results. Transcripts (selected excerpts – see Appendix Q), my codebook, analysis procedure, and results were all reviewed by peers (academic colleagues) several times during the analysis process. Feedback provided by peers was considered and incorporated as the emergent analysis process went on. During these

²¹ I have also referred to member checks as review process, interchangeably.

meetings, both the process of the research and the interpretations that were developing from our engagement if various research projects were examined and discussed to increase clarity and accountability of the research. This peer group consisted of both males and females.

When I was asked to do a guest lecture for an advanced qualitative research methods class at the university, I provided each student with the selected excerpts document (see Appendix Q) via email prior to my scheduled lecture. I asked the students to read the document and practice coding using my sample of real, *raw* data. I did not provide the students with my specific research questions as I wanted their feedback to be *uninfluenced*. Several of the codes they came up with were similar to the ones I was working with – in initial category development – as well. Some of the codes included pressure, power, manipulation, anxiety, overwhelming and negative (frustrating) feelings. I was, however, surprised at the depth at which the students indicated that they felt there were systemic issues and power and control issues present from having read just a few pages of transcript. One student (who had not given birth) specifically indicated she felt the “system is set up to detach people from their emotions.” She also described a feeling of mass production and again emphasized that the one word, or rather feeling, she had following reading was “detachment.” I went into the research project having certain beliefs and assumptions, which it was necessary to be reflexive about. Some of these related to my assumption about the way in which systemic function supports or does not support attachment. I have remained cautious of my ability to ‘jump’ to such conclusions. To hear from these few students (n=6) that they found these issues to be so ever-present in just the small amount of transcript I provided was reassuring and reaffirming for me that I was not just “seeing the things I wanted to see” in the data.

I also included nonparticipant acquaintances as part of my analytic process. The acquaintances were both men and women and several who also had not personally experienced childbirth (meaning neither they nor their partners had given birth). I included this third group as part of my review team because I felt they would provide another set of eyes (the most “outside” the research of all) and opinions regarding the conclusions I was drawing.

Dependability. According to Lincoln and Guba (1985) the dependability of a study is the way a researcher reveals her/his methods (i.e., transparency of the researcher and the researcher process). Therefore, in an effort to maintain transparency throughout the project, I kept a reflective journal, worked with the peer debriefing group, and frequently collaborated with mentors and major professors regarding the process, my feelings, and the experience. Transparency, for me, also means that in the report of my findings and methodological procedures I will attempt to inform the reader, as best I can, not only about how I came to know a particular “thing,” but also to offer some understanding of why I came to know “it” the way I do. Additionally, I have provided an audit trail (see Appendices H - Q) to offer a visual representation of the analytic process I undertook for this study. The audit trail is intended to reveal not only the theme development process and/or the way in which my sample was selected, but also allows the reader to see the process from beginning to end (Brotherson, 2010).

Transferability. Transferability refers to the way in which the results of a project resonate with readers (Denzin, 1977 as cited in Creswell, 1998). Through the use of thick, rich, description and context specific details of the women’s experiences along with evidence from the professionals, my account of the culture, and the lived experiences of the birthing

experience, I intended to portray an “I-know-that-feeling” kind of experience for the reader. As Bloom (1998) so clearly set forth in her book, a goal of feminist researchers is that readers will hear the voices of participants and feel called to act as a result of reading the findings. I embraced this goal as one of my own for this research project. One way I tried to enhance and ensure the transferability of this research was by using the feedback form, which I created and provided for each reviewer (see Appendix O). Two questions on this form specifically were intended to address this issue of transferability: (a) what did you connect with -- did any pieces of information resonate with you, and (b) what do you feel you could not relate to -- did any pieces of information not fit with your own understanding about birth or your personal experiences with birth?

Confirmability. For me, and for this research project, confirmability meant that (a) others would have drawn conclusions similar to my conclusions from the data and (b) the results are not simply because of my subjectivity and biases (Bloomberg & Volpe, 2008). Peer debriefing and triangulation were intended to provide evidence of this study. The Background Information section at the beginning of this dissertation is an example of a decision trail. In that section, I discussed the reasons I am doing this project, how it was shaped by previous research experiences, and thus what it has become to this point. In addition, explaining data analysis decisions and collaborating with participants during the process added to confirmability of the study findings.

Challenges and Ethical Considerations

In addition to these specific supports for trustworthiness that Lincoln and Guba (1985) offered, it is also necessary to consider research ethics as supportive evidence of a high quality study. With any research endeavor, ethics are an important and ongoing

process, but when conducting qualitative research – when the researcher is the instrument – ethics become tightly interwoven with the quality of the study.

I briefly mentioned transparency when discussing the notion of credibility of my study but I mention it here as an ethical issue. Throughout engagement in the research process, it was necessary to frequently reflect on personal biases and subjectivity and how these influence the process of research – also known as reflexivity. As a feminist researcher, my goal for this reflection process was not to reach objectivity but rather to question the essence of personal subjectivities and their influence on the person and the process (Bloom, 1998).

In a broader sense, I was granted approval for my study from the Institutional Review Board (IRB) at Iowa State University. I provided the review board with my study design, potential interview questions, recruitment material, and my informed consent document (see Appendix R). I disclosed how I planned to select participants and what my interactions with participants would be and for how long.

Along with the challenges and ethical issues I have discussed, I want to note two things: (a) "ethics" were not considered a unitary concept but rather as ongoing and emergent throughout the entire research process, and (b) addressing these ethical issues in my study lends itself to another piece of evidence to support the trustworthiness and rigor of the project. Navigating these issues was intended to produce high quality work and it was therefore necessary to keep these ideas in constant negotiation and at the forefront of my research as I engaged in this project.

Presentation of Findings

Although categorical and thematic generalizations were sought and made from the data in order to address the research questions, I also considered, and privileged, the stories (narratives) shared with me as complete in and of themselves. Because I employed a feminist and ethnographic approach, I did not always seek unified understandings (themes) from the data, but rather I aimed to share the uniqueness of each voice and the culture I was exploring (Bloom, 1998; Madison, 2005). Thus, in addition to portraying results in some thematic/consolidated manner, as a feminist researcher I found it equally appropriate to highlight each woman's story and experiences for its uniqueness. Therefore, I presented the results (Chapter 4) of this study in two parts. Part I is a collection of stories (narratives), both the women's and the professionals' lived experiences as [re]told by me, the researcher. Part II is a reduced representation (thematic/generalizations) of the data as shared with me and then analyzed in the manner described above (data analysis). The third group of women (cohort group) is featured only in part II of the results chapter in their own – stand apart – section. The primary reason for this representation is due to the fact that during my engagement in the research I came to the conclusion that setting a research goal of assessing change over time was not best suited to be addressed with qualitative research methods. It does not change the fact that the goal is perhaps a “good” one, but simply not something I was going to be able to adequately address with my methods. However, I still wanted to honor this as an original goal and share the results from this group of women. I used the web program wordle.net²² to create an interesting visual representation of the data that were

²² According to the website (www.wordle.net), “Wordle is a toy for generating ‘word clouds’ from text that you provide. The clouds give greater prominence to words that appear more frequently in the

collected from this group. I asked each woman to give me three words (or phrases) that they would use to describe their experience with childbirth. I took these words and phrases, for each cohort group, and entered them into the wordle.net program and created a word picture, or “word cloud” as the creator refers to them, as a means to represent this data (shown in the findings chapter, part II).

A key element of feminist inquiry and all critical research that I embrace is the concept of emancipation in the work. Therefore in order to embrace this foundational element, I suggest that it is necessary that the [re]presentation of findings from my work, *constructing meaning and understanding with women regarding their childbirth experiences in America’s maternity culture*, are aimed to emancipate other women. I propose that the interpretations and findings generated (and produced) through this project – a feminist critique – be represented in a format that is best suited to reach the intended audience, women. The results of this project are herein formatted to meet the requirements for a dissertation as defined by the Graduate College at Iowa State University. Beyond this document, it is my desire to write a book intended for a general public audience as an outcome of this research project following completion of this dissertation.

In addition to my desire to empower and emancipate women with this project, which in turn may eventually bring about a change in the maternity culture in America, I also hope the professionals who work with women also will benefit from this work. Ultimately however I view the voices of the professionals I have collected, analyzed, and presented as secondary to the voices of the women; the voices of the professionals serve to support my

source text. You can tweak your clouds with different fonts, layouts, and color schemes. The images you create with Wordle are yours to use however you like. You can print them out, or save them to the Wordle gallery to share with your friends.”

research data about women's experiences. It is possible that the professionals' involvement in research designed to emancipate and empower women could help them gain a better understanding of the subjective experiences and feelings of women and thus be better able to meet the diverse needs of their clients. Perhaps involving the professionals will have a secondary effect that some of them will throw their voices into building the case for change in maternity care in the direction of empowering women and letting women's voices be heard on this topic.

Since the 1960s, there has been a call to humanize the birth process (see Wagner, 2001). The World Health Organization (WHO, 2007) also has established humanization as a goal for maternity care in the new millennium. I suggest that through education and critique, American women may find empowerment and support in their experiences within the maternity culture. My dissertation followed by my book will serve as an avenue to offer both research-based analyses, empowerment to women, and support which in turn could lead to emancipation.²³ As the well-known anthropologist Margaret Mead stated, "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever has."

²³ "The critical ethnographer also takes us beneath surface appearances, disrupts the status quo, and unsettles both neutrality and taken-for-granted assumptions by bringing to light underlying and obscure operations of power and control. Therefore, the critical ethnographer moves from 'what is' to 'what could be'" (Carspecken, 1996; Denzin, 2001; Noblit, Flores, & Murillo, 2004; Thomas, 1993, as cited in Madison, 2005, p. 5).

CHAPTER 4

FINDINGS AND DISCUSSION

This findings chapter will be presented in two parts. Part I includes my [re]telling of each participant's (women and professionals) stories; I have titled this section, Birth Stories. The birth stories are intended to provide the richness and context of both the lived experiences of the participants themselves and also my experiences with them. Another aim in sharing these birth stories as part of this chapter is an attempt to respect one of the goals of feminist research, which is to honor each woman's story and not to simply reduce those experiences to bits of data. In order to ensure that my interpretations and [re]telling of these stories were both appropriate and accurate, each participant was provided with a copy (electronically) of their story. I asked for their approval and also requested that they provide any editorial changes they felt were necessary. Of the 12 participants, nine provided their formal approval (electronically) of the narratives I had created from their conversations with me.

The second section of this chapter – Part II: The Modern American Birth Experience – is presented in eight themes. These themes were constructed following the rigorous analysis of transcripts, notes, and memos. The themes were created using the combined data from both women and professionals to provide a snapshot image of the modern day American birth story. Participants, as well as professional and academic peers, were provided with the preliminary write-up of these themes and asked to provide feedback regarding their thoughts and feeling about them. Their feedback was then reviewed and used during my final analysis, which led to the concretization of the themes presented in section II.

Part I

Birth Stories

Eleanor's Story: The Bumper Sticker

I met Eleanor in a parking lot! I had seen her car around town perhaps once or twice. It is a station wagon-SUV-crossover type vehicle, but that's not the reason I remembered I'd seen it before. There are several bumper stickers on the back of the vehicle and one caught my eye. It said, "The hospital is for sick people, birth belongs at home." Given the nature of my research, when I saw that I thought to myself, "I bet the woman who drives that car would have some interesting things to share with me." Then one day the only empty space I could find in a parking lot was next to this car. Although I love my research topic and this work that I'm doing, I'm not in the habit of approaching strangers – and certainly not to ask them to share their birth stories with me. However, I felt it was a sign. I told myself that if I were to see whose car this was that I would have to muster the courage to go introduce myself. Sure enough the driver of the car appeared -- a very pregnant Eleanor! I sat in my own car for a moment and convinced myself to go say something. I briefly introduced myself, told her why I was being a "weirdo" and approaching her, and asked if she would be interested in my sharing with her some information about my research that she could consider if she wanted to participate in after her baby was born. She gave me her email address and I sent her some information. She agreed to participate; about a month later her daughter was born and just a few days after that she invited me over to her house for a chat.

Eleanor's home is eclectic and kitchy. She has books overflowing from the shelves, photos of travels to far-away places, unique artwork, and mismatched furniture. Her home is warm and inviting and I'm sure every piece in that space has a purpose and a unique story. It

was obvious that she does not decorate to “trend,” but rather in a manner that makes the space memorable and purposeful for her family. I would have loved to stay and find out more about all of the “things” in her life, but my time with her that day was to hear her stories of birth, so that is what we did – talked about birth.

Eleanor’s story started with a “dumb policy” at the local OB-GYN clinic. Sadly Eleanor had had a miscarriage just a few months prior to conceiving again with her son, who was born in 2006. It was standard policy that all maternity patients at her local clinic (whether with the midwives or OB’s) attend a nurse practitioner appointment as their first (welcome) appointment. Having been pregnant just three months prior she had recently been to this appointment. Additionally, having miscarried before 12-weeks she was somewhat anxious about the first trimester of this pregnancy. When she called to schedule a pre-natal appointment with her midwife they informed her she would first need to attend the “welcome appointment.” She told the receptionist that she had just been to this appointment; she even still had the material they had provided. She asked if she could see the midwife, since she was nervous about the pregnancy, and skip this appointment. She argued that since the information they planned to provide had not been changed there was little point in going over it again. They told her this was not an option and she would have to wait to see the midwives at this clinic until after 12-weeks so Eleanor decided to look for different options.

Eleanor was not looking for homebirth, just for another option. Hospitals make Eleanor nervous and anxious, she said, so in the end of the search for options, homebirth just made sense to her. She met with a certified nurse midwife (CNM) who had the same training, education, and certification as the midwives she would have seen at the clinic, and Eleanor liked her very much. The midwife she chose for her homebirth was “extremely

experienced.” There was nothing this midwife could not provide at home short of a cesarean that the hospital could provide. Eleanor and her husband felt that since they lived so close to the hospital that they would be able to arrive there by the time an operating room could be prepared for surgery anyway. Eleanor had done her research and felt this was a safe and logical option for her.

Eleanor’s labor began a few days before 41 weeks. Her son was in the posterior position²⁴; this positioning of baby can cause a lot of back labor for the mother and is not an optimal position for delivery – it can prolong labor and increase pain for the mother. Eleanor “did everything in the book to get him to turn, but he wasn’t turning.” Her labor began with the rupture of her bag of waters in the middle of the night and increased quickly. There was no early labor build up, just “bang” intense labor. Her labor was not easy for her; “it was very intense -- it hurt.” At some point during labor she stalled (she stopped having active contractions). Eleanor’s midwife was patient and waited for labor to get going again, but Eleanor remained stalled. The midwife and Eleanor talked about what might have been going on emotionally and psychologically which might have been influencing the labor stall. Eventually the two decided that some of Eleanor’s own anti-anxiety medicine might be what was needed to help her relax, so she took the medication. She spent the rest of her labor in a birth tub. Eleanor was finally relaxed and barely an hour passed before she was pushing.

Due to the posterior position of the baby (sometimes called “sunny-side up”) Eleanor’s midwife was cautious of the position she delivered in – she wanted to be sure to

²⁴ The back of baby’s skull is at the back of the mother’s pelvis – often referred to as “sunny-side up,” meaning that the baby’s face will deliver first, rather than the top of the skull.

avoid potential shoulder dystocia²⁵ issues for the baby. After pushing for a while (Eleanor could not remember how long) the midwife asked her if she wanted an episiotomy. Eleanor laughed as she recalls that she asked, “Will it hurt?” Eleanor said the idea of the episiotomy may have been just the incentive she needed, because the baby’s head was born with the next push! Following the birth of her son in water, Eleanor moved to the bed to deliver the placenta and for aftercare. Eleanor was bleeding more than what would be considered typical after the placenta delivered and since she had become anemic during her pregnancy, she was given a shot of Pitocin to help her uterus contract and reduce bleeding - it worked fine. Although both she and her son were healthy and ultimately her birth went as she had planned (at home) Eleanor said it was “a traumatic birth.” “The labor was intense, long, and hurt a lot.” Because of this it took her and her husband a long time to think about having another child.

Just over three years later they found out somewhat unexpectedly that they were expecting again. Immediately they got in contact with their midwife from the first pregnancy and began to plan their birth. The pregnancy was “uneventful;” however, Eleanor said she suffered with morning sickness throughout most of it – up to 36 weeks. At the end of the pregnancy she started having a lot of “false labor,” and this went on for weeks. She began to get very frustrated with it because it was frequent, but felt like it (the false labor) was not doing anything. Eleanor went post-dates, past 40 weeks, and then past 41 weeks -- experiencing the false labor constantly, but not the real labor.

²⁵ A condition which can result in some numbness and limited use of shoulder or arm. In most cases the condition is temporary, but could potentially result in long term complications for the child.

She was seeing a chiropractor, getting massages, using a support belt to belly bind, and even started seeing an acupuncturist to try to bring on labor, but nothing seemed to work. The day after 41 weeks (just a week prior to our conversation) Eleanor spoke with the midwife about an induction in the hospital – something Eleanor wanted to avoid very much – if labor did not begin within the next week. Eleanor knew she had just another week for labor to start on its own or this would be her fate so she was desperate. That day while at the acupuncturist, labor finally started. Despite her knowing this was it, she still “doubted it a bit, due to all the false labor” she had been experiencing. She called her husband and the midwife but opted to have lunch with her mother instead of rushing home. After all, she knew she would need the energy and she “was really hungry.” During lunch she finally wrapped her mind around the fact that this was real labor.

By the time she got home from lunch, not much more than an hour or so later, she was in “very active labor with intense contractions.” She “started vocalizing” [moaning and making noise] a lot during the contractions” and felt like she was already nearing transition (moment between contracting and pushing stages). She started to doubt herself. She remembered thinking, “I can’t do this; I can’t make it through.” Her midwife did a cervical check and told her she was complete (100% effaced and 10 centimeters dilated). Eleanor got into the pool (birth tub) and immediately her contractions were less painful. She believes this was a combination of the water and the mental aspect of knowing she was complete. She thought to herself, “Oh, I can totally do this!” Eleanor said she felt her daughter move down and engage and before she knew it she thought, “I have to get her out now.” She says she “could not hold it or stop it;” her daughter was coming. Her daughter was born in the water and weighed 9 pounds and 3 ounces. Eleanor commented that the position of the baby (not

posterior, like her first) made a big difference in the birth. Her second birth was emotionally healing for her from the trauma she felt from the first one.

As we concluded our conversation that day, new daughter in arms, Eleanor shared with me some of the misconceptions that she experienced regarding homebirth. “A lot of people assume that homebirth means no care.” Eleanor reported that she was often called “crazy” or “brave” for giving birth at home. She finds that women will often say “Oh that’s great, but I could never do that: it’s too high risk for me.” Eleanor’s midwife has a theory, apparently, about the idea of high risks. She believes that most women who are labeled high risk are in fact not and that through proper holistic care she can take a “high risk” pregnancy and make it “low risk.” I asked Eleanor what her thoughts were about the climate of the culture of birth at the time of her experiences. She said that she went “post-dates with both and with her second everyone was asking when my induction was,” specifically women her own age. However, she noticed that older women, like her mother’s age, were not asking this.” The questions about an induction date got to be so common and frustrating for her that she found she simply wanted to avoid people altogether.

Eleanor wrapped up our time together by commenting on how “everyday” her birth at home seemed to be. “You know, that night we were all just home. And we ordered a pizza. That was so nice to just be with my family.” There were two things that stand out to me as unique in my experience with Eleanor. First, no other woman was so “fresh” from their birth experience as she was. She was holding a brand new baby less than one week old in her arms while we had our conversation. That was a fun honor for me to be invited in to her life, as a “researcher,” so soon following that intimate experience. And secondly, it was very interesting for me to consider that less than a week prior Eleanor had given birth in the very

room where we were sitting. It was very surreal for me to actually be in the very space – emotionally and physically – where she had brought her daughter into the world.

Emma's Story: A Perfectly Healthy Little Girl

I met Emma when I was pregnant in 2007. She and I took a “Moms in Motion” aqua aerobics class together two nights a week. Prior to becoming pregnant Emma had been a social worker for the state. Once pregnant she found herself even more burned out on a difficult job and decided to find a new position, which was a bit easier on her heart as a mom-to-be. Given Emma's years of experience as a social worker, and my status (at the time) of being a mental health therapist, we did not struggle to have plenty to chat about. We were pool-pals for the next two and a half months, until she was prescribed bed rest at 34 weeks. Emma and I, along with a few other women from our aqua class, have maintained a friendship over the past three years and get together once every couple of months for moms' coffee or play dates with our children.

Before entering graduate school for a second time in my life, I had already been slowly integrating myself into the role of childbirth go-to-gal among my groups of friends. So my research was not unfamiliar to Emma and other friends, as childbirth is a not-so-uncommon topic among women friends. I shared my recruitment flyer (see Appendix A) with Emma among several other friends and asked them to distribute it for me. Several friends were not only willing to assist in recruiting -- they were willing to be participants. While completing my mini-thesis (Hardy, 2010) I had found that women who were acquaintances of mine were more willing, it appeared, to disclose more personal (emotional) experiences with me regarding their childbirth experiences. Therefore, I found it appropriate

to include willing friends in this research. One cold winter day I ventured over to Emma's office for a lunch date and a chat.

Emma's story of childbirth, like so many others, started with conception. Emma and her husband of ten years had struggled to get pregnant and after years of trying sought fertility treatments. Emma was diagnosed with polycystic ovarian syndrome, a condition which affects ovulation and hence the ability to conceive. After several rounds of fertility treatments Emma conceived in 2006. Sadly, that pregnancy ended in a miscarriage in the first trimester. Emma shared that she had a lot of guilt over the loss. Despite the years of trying, Emma said,

I think I just wasn't sure I was ready. I mean, I know I should have been. I did want that baby and that pregnancy. I guess I just blamed myself for awhile – and still do a bit. Like, if I hadn't thought, "Oh, I don't know if I'm ready for you baby, . . .

After the miscarriage Emma and her husband decided they needed to take a break from trying to conceive. After several months they decided to change providers and opted to start trying again. In early 2007 they were successful.

Emma and Tom, her husband, were very reserved and reluctant to share about their pregnancy given their experience with miscarriage. For the first several weeks of pregnancy Emma had to continue seeing her fertility specialist, but eventually as she stated, "We graduated" and she started seeing a local obstetrician. "For awhile I think you just doubt it, like was I really pregnant? Was this real? I just didn't believe it." As the pregnancy progressed and they reached the second trimester they began to believe it and were more willing to share their excitement with the world. Emma was due around Thanksgiving and Emma, the baby, and the pregnancy were all healthy.

Baby showers were held and a nursery decorated. Emma and Tom chose to find out the sex of their baby during what Emma called “a standard battery of tests they have you do.” She felt that knowing the sex of her child – a little girl – would help her dialogue with her yet-to-be-born child. A few days after the battery of tests Emma received a call at her office; it was one of the nurses from the clinic. The nurse told Emma that one of the tests came back indicating that their baby might have downs syndrome. “Panic set in” and emotions overwhelmed her. Her mind “went right to worst-case-scenario.” “What does this mean for our family, how am I going to do this, why is this happening, the works.” Emma said the nurse gave her a “spiel” about how the test can produce a lot of false positives and that she should try not to worry yet. The nurse told her she would need further testing to either confirm or falsify the report. A few weeks later, Emma and her husband drove to a clinic 50 miles away to undergo another series of tests and in the end, “The first test was absolutely wrong.”

Emma told me the rest of her pregnancy was “fine” until around 34 or 35 weeks when she went to her doctor’s office for a regular test. She said they took her blood pressure and then looked at her and said, “Lay down.” Immediately she was put in a wheelchair and taken across the street to the hospital. She said, “They admitted me and told me they planned to observe me overnight.” The next morning “They let me go home, but they put me on bed rest.” A week later Emma had a follow up appointment (a few days prior to 36 weeks) and “they decided it was back to the hospital.” Emma was monitored again overnight, and she believed things were going well; she thought she would be discharged in the morning. Instead, with the morning sun came an induction. Apparently, the doctors did not like the

blood pressure numbers they were seeing and felt it was time to “get her out” for Emma’s and the baby’s safety.

Emma said she was a little afraid of birth. She said this fear “came from the media” and the messages she had heard from other women. Emma told me that her mom spent a lot of time trying to convince her during her pregnancy that “I should not trust the TV; it’s so dramatic and not real. In her experience it ‘wasn’t that bad.’” During Emma’s pregnancy she was watching a popular movie, released in theaters in 2007, which featured a birth scene at the end – intended to be comedic. “It was so horrible. I had to shut it off,” she said about the movie. Despite some fears and anxiety Emma felt it important to “stay relaxed and not let things stress me out.”

As for the plan for her birth, in addition to not having anticipated an induction at 36 weeks, Emma had always planned to use pain medication. “I’m kind of a wimp, so I didn’t even want to try unmedicated.” Although this was her plan, her doctor also indicated that she would “require” Emma to have an epidural. The doctor explained that she felt this would help keep Emma relaxed and would avoid her blood pressure going up to a level that would be dangerous for both Emma and the baby. Once Emma was having steady contractions, an epidural was administered and the doctor stated, “You’re looking okay, we’re not going to do anything else right now.” She was able to rest and even slept while her labor progressed. The nurses came in every half hour to “roll me over,” she said. “I just checked out and relaxed.”

While still feeling a bit “out of it” Emma said she started to feel funny, kind of like pressure. She asked one of the nurses about it and when the nurse pulled the blanket back to check, her daughters head was being delivered. “The look on Tom’s face was priceless,”

Emma said. The nurse scrambled to call the doctor in, tossed the blanket back, and “threw” Emma’s legs in the stirrups, but the baby did not wait for the doctor. “She just delivered herself right there to the nurse, she wasn’t going to wait for anybody. And there she was, this perfectly healthy little girl.” Emma and Tom had been “being warned,” she said, “all day about the risks and complications of having a baby born 4 weeks early.” “They’d been preparing us for this worst-case-scenario, and so we were ready for a rush to the neonatal intensive care unit (NICU) and respirators, all that, but she was fine.” Emma and Tom were “so grateful, because so many things could have been.”

The doctor was shocked to find she had missed the entire birth, but was there for the aftercare. Emma’s baby girl was given formula with iron right away. Emma was not sure what was wrong or why it was needed, but she truly trusted her care provider’s judgment that it was necessary. I asked Emma about the emotions she was feeling in this moment and she said it was “so strange going from one to two.” Emma had a lot going through her mind in those first moments holding her daughter, “the infertility, the bed rest, the induction, all of this and still feeling in a bit of a fog from the delivery.”

A couple of days later Emma, Tom, and a new baby girl went home. Upon walking into her house Emma said she “sat down on the couch and bawled, just cried and cried.” At just 36 weeks she just was not ready for the baby to come yet, not to mention the emotions of infertility and a previous miscarriage, which she had carried with her through the pregnancy.

There must have just been this weight that I was carrying, and once in the confines of my own house I felt safe enough to let it out. Just to be able to release those tears . . . that everything was okay.

Emma had significant struggles to breastfeed and said it was extremely emotional for her. “It was a major stress of desperately wanting to breastfeed, and it not working.” Emma

worked with a lactation consult (LC) for the full 12-weeks of her maternity leave and tried many different things to be successful with breastfeeding. She was told by the LC that having a premature baby (preemie) and being big breasted might be two factors affecting her ability to breastfeed.

It was never meant to be. For me that was the hardest thing to let go. I think it was admitting failure in some way. Breastfeeding was something I always wanted to do. I felt I was being deprived of something. I spent a lot of time crying about that. It was very overwhelming.

For the first weeks of her daughter's life, Emma was not allowed to leave the house except for doctor's appointments, because her daughter was a preemie. "Thinking back now (three years later) there could have been a little depression. I really had to just be stuck in the house and not allowed to go anywhere." Feeling trapped in the house and struggling with breastfeeding continued to leave Emma feeling in a fog for some time.

As Emma and I wrapped up our conversation this day, I asked her to tell me how she would describe childbirth to someone who wanted to know what childbirth is like in 2007.

It's very medicine focused. Especially for me, because my body [was] shutting down. For me, I just put my faith in the doctor to make all the decisions for me. Ultimately I had to put all my trust in her to advise me what was the best decision for both of us (me and baby)."

For Emma, as she said, "... and, it all worked out."

Isabella's Story: The Next Appointment

Isabella is an extremely approachable and friendly woman. She is sincere and kind and knows how to have a good conversation. She is 36 years old and the mother to one little boy, born in spring of 2008. Isabella and I met for lunch one day at a local restaurant to discuss her birth experiences. We found ourselves a little corner in which to sit and chat and began our interview. Isabella's welcoming demeanor encouraged the natural flow of a

conversation so our chatting that day began easily and continued for just over an hour, but I easily could have continued for longer.

Isabella had been trying to conceive for nearly a year before finally getting pregnant over the summer of 2007. She never formally underwent fertility treatments, but she states that she tried many “tricks” to conceive. Simply put, it was not “easy” for Isabella and her husband to get pregnant. However, it was not the details of getting pregnant which began our conversation that day. Isabella started by sharing that she was “not a fan” of medical settings. She would be a likely candidate for what is commonly referred to as “white coat syndrome.” She has generalized anxiety disorder (GAD)²⁶ to begin with and shared with me that being in a medical setting causes her blood pressure (BP) to be higher than “normal;” this would then “cause the medical professionals to get a little nervous about managing the BP and the cycle would repeat itself.” Our conversation seemed to hover around these points of fear and anxiety for most of our time together that day.

Isabella stated that she felt fine during pregnancy and that it was “uncomplicated,” but struggled to allow herself to “accept” this status of “healthy.” She spent most of her pregnancy wrapping her mind around the idea that “everything was okay,” and just as she would maybe be convinced of this in her head it would be time for another appointment and her anxiety levels would shoot through the roof again. She stated, “My fear and anxiety was just like...whoa! Yeah, it was a lot.” She spoke several times about feeling that she needed to relax and just enjoy her pregnancy, but the idea of doctor appointments would “loom” over her and she would panic.

²⁶ Isabella shared during the review of my [re]telling of her story that her GAD is specific to medical situations, “not just everyday life.”

When I asked her if there were specific issues that were influential in her anxiety levels around medical settings she stated, “It was a lot of the not knowing. What tests are they going to run next? What are the doctors thinking? What are they writing in my chart about me?” At one point her husband came to an appointment with her to help advocate or as she said “lay down the law,” on her behalf. Her blood pressure was fine outside of the medical setting and he requested the doctor “ease-up” on the testing and “issues” they were having with her BP. They even provided the BP readings they had been getting when she was at home – not anxious – as evidence. Although Isabella felt the readings were considered they were still “not enough” for the doctors – “they wanted to do their own readings, in the office.” Isabella stated “they were not willing to consider any BP readings valid unless they had done it in the clinic.” Isabella felt very unheard and with that her frustration and fear levels increased.

Due to her GAD Isabella regularly sees a mental health professional to help her cope with her anxiety. This therapist even wrote a letter to Isabella’s doctor explaining her GAD and the specifics of the condition as it related to medical settings to try and advocate on Isabella’s behalf. Isabella mentioned that during her pregnancy she really appreciated her therapist’s support. She said, “She saw me as a whole person. Emotionally. Spiritually. The whole me. I was not just a chart to her, I was a person.” Isabella mentioned several times how she felt that if her doctor could just see the “whole her” then the “BP thing” would not have been such an issue. Eventually the experiences got to be very emotionally draining for Isabella.

There was just enough of appointment after appointment that at some point I just kind of turned it all over and said, well, I guess the doctor’s going to know best, and I’m just going to have to bite the bullet and just do what they want me to do.

Isabella's labor began when her bag of waters ruptured. Contractions followed and she and her husband made their way to the hospital. Upon admission, an IV was immediately started and when she asked why this was being done she was informed that her "chart indicated pregnancy induced hypertension (PIH)" – high blood pressure during pregnancy. She said, "But, I don't have PIH. And they just said, 'Well it's on your chart, so you need the IV.'" Isabella stated that since the doctor on call that day was not the typical doctor she saw for appointments, that doctor had no way of knowing the circumstances as to why anything that was written in the chart – only that it was written there. It appeared that Isabella was more frustrated that apparently she had been given this diagnosis – one that would require the hospital to perform certain procedures on her during labor – and she was not aware of it. And, in fact, she feels she had been "advocating" for herself and felt defeated that she had not been successful in avoiding certain procedures in the end. She described that the remainder of the admission routine after that became "very scary." "Well, I guess I have no choice, and then I was scared," she said.

I began to wonder, how many more tests, what are you thinking, what else is written on my chart? Why am I being plugged with an IV, and why, why do I have a blood pressure cuff on me all the time? Why can't I get up from this bed, and what's going on?

She used the word "attacked" to first describe what she felt like upon admission, but then said, "No, I guess I just felt bombarded." Although she said she did voice some of these concerns, the answers always fell back on two things, "Well, we just don't want anything to happen to baby, okay" and "Well, your chart says."

Isabella had planned to try for an unmedicated birth, but at 8cm dilated she decided to have an epidural administered. Once she was complete²⁷ she had indicated on her birth plan that she wanted to labor down²⁸ on her own and she was “surprised” that the doctor let her do that. However, after two hours complete without feeling any natural urges to push the doctor indicated that “it was time to move things along and get the baby out.” Isabella said the doctor was going to “help baby’s head come down” and that the doctor was “more comfortable with forceps.” When I asked Isabella if the necessity to intervene in this way was explained she said, “No.” Isabella never pushed. She added that she felt, “If it’s going to prevent a c-section, get on that.” Isabella says that she assumes the procedure “must have been necessary for the doctor to make the decision.” She says, “I could feel pulling, like baby wasn’t engaged. I felt pulling a lot of pulling and could feel an internal pop of pressure. It’s a weird feeling – hard to describe.” Isabella told me that she did not feel her son come out but that she did feel the delivery of the placenta. Describing the birth of the placenta, she states, “I thought it was cool and I wondered what it would have felt like to feel baby come out. It was just a *swoosh*.” She shared that she “mourned at that moment, because her son was not in her anymore. It was just kind of sad for a moment. Like, he’s his own person, not connected anymore.”

I asked Isabella to share what her perceptions were about birth leading up to her experiences and she said she believed that “It was going to hurt and be bad.” She laughed about this and stated that “this perception and [her] anxiety-levels did not interact well to promote relaxation” during her pregnancy or labor. We then spoke about where she believed

²⁷ Fully dilated and effaced.

²⁸ Following complete dilation of the cervix (10cms) labor down describes waiting for the body to cue the pushing phase, rather than being coached to immediately push.

this image of childbirth came from and she stated quite simply, “The media.” Finally I asked if she would give me a summarization statement about her childbirth experiences with me.

To this she responded, “Doctors are in control and this is the way it has to be. You’re supposed to follow suit. You know there are no other options.” She went on to add another more personal statement,

I realized at some point that I wasn’t going to get to experience this because they are going to have me strapped to a bed. And I was really sad about that. But I didn’t say anything; you just go with the punches.

Isabella shared that she felt her nurse was “phenomenal” and she appreciated her support. However, she said that “having a doula would have been beneficial.” “I thought the doctor would get me through, and that was a mistake. Having more positive encouragement would have been nice.” She went on to connect the feelings she experienced during her birth to the way she felt parenting. Isabella says that she felt she transferred some of her medical apprehension to her son. Isabella felt that perhaps

If the birth had been different, like a more positive spin, I might have felt more of an “okay I can handle this.” Or if I had just heard, “it’s going to be okay.” I might have felt different in those first days.

During our conversation I really appreciated Isabella sharing something very personal, something that is somewhat socially stigmatized and often goes unspoken. This taboo topic is that of urinary incontinence immediately following birth. Isabella told me that when she was leaving the hospital “a nurse had to carry [her] son, strapped in his car seat, down to the main door and ensure that he was properly secured in the car.’ Isabella was not allowed – as per hospital policy – to carry her son, so she carried her bags. She said at one point, while waiting for her husband to drive the car around, she “bent over to grab something out of a bag and I wet my pants.”

She told me that in that moment she felt “that I lost my dignity” and “the nurse ignored [her],” despite having seen what had happened. She said she felt like the nurse could have offered her some reassurance that the experience is “common” and instead Isabella felt like “There was no respect for me.” “I thought you have no compassion.” She said that experience really left her on a “sour note.” For Isabella it was as if “The nurse didn’t even care about me as a human.” The nurse was “hurried,” like Isabella was just “another patient.” This concluding event made Isabella feel like her “body was broken” and she thought to herself, “I don’t know if I can do this.” We were talking about connections between birth and parenting when she shared this. We also briefly discussed breastfeeding and Isabella indicated that, “[the doctors] don’t leave you high and dry, but they also don’t give you that ‘it will be okay.’ It was scary.” As we wrapped up, Isabella again reiterated how much hearing “It will be okay” would have made a difference to her in feeling such comments would have been “reassuring, supportive, and nurturing.”

Sadly, Isabella said her experiences – the prenatal appointments, the diagnosis she was unaware of, as well as others – have specifically influenced her thoughts about future children significantly. She wants more children, but is unsure if she can emotionally handle the medical experience again. She said, “I’d like to be a little more involved next time.”

Judy’s Story: A Real Mom

Judy and I met for a conversation at a coffee shop on campus. She had responded to my call for research participants and being a doctoral student herself, in another department, she understood the need to help if she could. She was a funny, kind, and an extremely intelligent woman. My conversation with Judy was easy and light-hearted. She was honest and reflexive about her experiences and her feelings, which I deeply appreciated.

Judy was young, 19, when she had her first daughter in 1997. She was an undergraduate who had been on the depo-provera shot (birth control) and was planning to make a switch to a different type of birth control when she conceived. She was single, but in a relationship with her baby's father, and she is also a minority. Interestingly when she first went to the doctor at the student health center to take a pregnancy test to confirm what she already knew, before even saying the words "you are pregnant," they asked her rather if she wanted to "keep the baby." Judy did not hesitate to respond, "Yeah, I want to keep her."

As far as her knowledge of birth before her own experiences Judy said, "I knew it would hurt and I knew you went to the doctor." Beyond this she had not given it much thought. Judy also planned to "ask for some kind of pain meds as soon as I could have them." Being young seemed to have a lot of influence over how Judy conceptualized and made plans for her birth. The truth is she really did not have much of a plan and this was fine with her. Judy said she believed the "doctors know what they're doing" and she "had no issues" with allowing them to take the lead.

Going into her labor and birth Judy was afraid. She was afraid of how much it would hurt, she was afraid of pushing the baby out. "Logically there is a small hole that something really big has to go through, so it just seemed there would be a lot of stretching and tearing and that had to be very painful." She spent a lot of time thinking about pushing the baby out and simply "how the baby would come out without her feeling like I wanted to die." Judy also spoke about the influence the media had on her feelings and perceptions about birth. "You see all that stuff on TV about how much it hurts and how bad it's going to be and women screaming and cussing at their partners. It wasn't an image that made me feel good about it," she said. Yet somehow, contrastingly, she knew it could not be "that bad" because

women have more kids, but somehow she “just was not able to resolve that issue” in her mind. At the time, the only stories Judy remembers hearing from others were stories regarding “really long labors and lots of stitches.” Judy attended the childbirth class that was offered by the hospital. Her boyfriend told her that he did not believe it was necessary for her to go to a class to “learn how to have a baby, because women had been doing it for centuries,” but he was supportive of her nonetheless. Judy wanted to go because she “wanted to know what was going to happen” to her.

Judy’s labor was induced using Cervadil and Pitocin. She had an epidural as soon as she could. After approximately 11 hours of labor and “no progress” the doctor came in and said, “We can let you go longer and see how things go, or we can go ahead and get the baby out now.” Judy figured things might be fine if she waited, but this way she did not have to wait and she would not have to push the baby out. She said, “Alright, let’s go get her.” She thought, why hurt if I don’t have to? “So we had a c-section and they went and got her.” There was a lot of tugging, but Judy could feel no pain. Once her baby was out the doctors showed her to Judy and then “took her away,” Judy’s boyfriend went with the baby girl. “Then they closed me up, that was the gist of it,” Judy described. “The doctors and nurses all knew each other and they were talking casually” as they stitched her up. She described it as “a strange and lonely feeling.” She recalled thinking, “Hello, what about me?”

We discussed how some women have negative feelings about their cesareans, which were unplanned, because they feel that they missed some experience. Judy quickly responded, “I wasn’t excited about the experience so I didn’t mind. I didn’t want to have that experience in the first place, so it was fine with me.” I asked Judy if she felt her cesarean was necessary and she quickly replied, “No.” “My doctor was in and out all day and I think

just as much, if not more, than I was, he was like we can just get this done with.” Judy has no bad feelings about her cesarean; in fact, she had her second daughter by planned cesarean, seven years later, and if she were to have another child she would do it again, she said. She “did not have to push” and in the end she had a “pretty little baby girl.” Judy believes that had she had a different plan or desire in her mind about childbirth, she may have felt differently. I asked if she felt that ultimately she was the one making the decision to have the cesarean and this may have then helped her feel empowered by the choice and also helped with her positive feelings about the experience. She said, “The doctor told me what to do and I did it. I was really just, okay this is what you do, I’ll do it. There was not a whole lot of thought about empowerment and control.”

When her daughter was born in 1997 Judy qualified for the state food assistance program Women’s Infant’s and Children (WIC), which provides formula to moms for free. The fact that this product was “free, easy, and good for her baby” was all Judy needed to decide to formula feed. She stated that breastfeeding her second child was largely the result of her no longer qualifying for the WIC program and being “too cheap” to pay for formula. She did have some concern that she would potentially bond with her second daughter more than her first because of the breastfeeding, but in the end she believed that her bonding with her children began in-utero, not just once they were born.

As we wrapped up our conversation I asked Judy if she could summarize what the “climate” of the childbirth culture was like in her experience. She said,

You go to the doctors and have all the prenatal care. You also have to go to the childbirth class, to be sure you know what’s going to happen and then you plan. Pack your bag and have it all planned out.

As a follow-up I asked her what one piece of advice she remembers getting the most during her pregnancy. Judy said that she did not really remember getting much advice. She stated that she may have been pre-occupied with “all the other stereotypes – single, black, young,” and therefore, did not notice “these things.” In contrast, had she been a “soccer mom” she believes that perhaps people could have related to her more and she would have been given more advice.

Finally, we talked for a little about other influences on her perceptions and feelings about birth, both before and after her experiences. Judy does not feel any less of a woman or mother because she “didn’t have to push them out.” However, she does state that she sometimes “cannot relate to other women when they are telling stories about their birth experiences.” She states, “I just showed up, and an hour later they went in and got her” in this case discussing her second birth. She spoke about, “the women who tell their war stories. You know the ones about ‘I had to get 37 stitches and it was 32 hours,’ the bragging about their births.” Judy rolled her eyes as she said this and again reiterated that she might not be able to relate to these stories, but she does not want to be able to either – she’s a mother to her daughters regardless.

Layla’s Story: The Power of a Positive Friend

Layla received some information about my research from one of her friends. The next day I had an email from Layla, who recounted her experiences with childbirth. I responded to her email, thanked her for sharing, and asked if she would like to meet with me to tell me her stories in person. We made arrangements to meet in my office for lunch a week later. Layla was an attractive woman with a slender build, who dressed like a cute-fashionably-on-trend mom – something I long to be. Layla works in a profession that is

primarily male-dominated and would much prefer to be a stay-at-home-mom. Her husband tells her that her “earning potential is too high” for her to be able to do that. She works part-time and is home with her two children the rest of the time, and she is “thankful for that.” It is difficult to explain, but Layla and I seemed to have one of those instant connections, at least for me. I felt immediately comfortable with her and enjoyed our conversation very much.

Layla’s story of birth started with the rupture of her bag of waters at about 37-weeks gestation. The interesting thing about this portion of Layla’s story is that she believes that her bag of waters was actually “accidentally ruptured by the doctor during a vaginal exam.” Just a few weeks prior one of the doctors, in a group practice, informed her that her “uterus was high,” not a problem, per say, but it apparently made it a bit trickier for the doctors to “find” during exams. She stated that during the vaginal exam at her 37 week checkup she felt like it was taking a long time and the “doctor really appeared to be searching quite a bit and a bit aggressively.” When leaving the clinic after that exam she first felt “a gush of water.” It was enough to make her feel she needed to go home and change clothes before returning to work, but she did not think that it was really a rupture of her bag of waters. After all she was just 37 weeks along, she still thought she had at least three weeks, “so I wasn’t ready,” she said.

She called her sister, who had experienced childbirth, to ask for a description of what it felt like to have the bag of waters rupture. She was still trying to convince herself that it must not be true for her. Layla’s doctor’s appointment had been in the morning and by afternoon the water had kept coming – a slow trickle – enough to warrant a phone call back to the clinic. “I think my water broke,” she told the receptionist. She spoke to a nurse who

informed her that sometimes there can be bleeding or other discharge after an exam, but to be sure they needed her to come back in to be checked. Her husband met up with her at their house and they brought their bags (for the hospital stay) along with them, just in case. At the appointment it was confirmed that her bag of waters was indeed ruptured. “Do you think the doctor this morning accidentally ruptured it?” Layla asked the physician she was now seeing. “Well, there is no way you can prove that,” the doctor responded. “They instantly covered their butts,” said stated. Layla told me she “didn’t care,” but just wanted to know what happened; it seemed early and odd to her. “I’m not trying to blame that doctor, but I think it’s pretty evident that was the case.” Nevertheless she and her husband headed to the hospital and checked in.

Since Layla had not had any signs of labor (contractions) since the rupture of her bag of waters in the morning, nearly 12 hours, she said, the doctor “put me on Pitocin to induce labor because they kept telling me I was running out of time.” I asked her if they talked to her about her options and the risks and benefits of Pitocin or the option to not have it and the risks and benefits of that. I asked her if there had been informed consent, to which she replied, “They didn’t give me the option, they just said, ‘We’re putting you on Pitocin.’” She said that she had heard, from other women, that once her water had broken she “only had twelve hours to have the baby before you would have a cesarean.” So even though she did not hear the doctor provide that specific 12-hour timeframe, it had already been in her mind.

She shared that her “labor was challenging I went from nothing to full blown contractions, pretty close together, in a matter of minutes.” Because of this fast and “ka-pow” labor she, “went ahead and took the epidural.” I asked if this had always been her plan. “Well, I wanted to at least try to labor without pain meds, but I was open to an epidural.”

Layla indicated that all her friends down to even her hairdresser, simply “everyone” she talked to told her, “Why go through all of that if you can get an epidural? The technology has progressed, the baby is fine, why do it natural, it’s so not worth it” and with that Layla decided she was open to the epidural. Approximately six hours later on a December night in 2006, her son was born. She said, “He was healthy and ready to eat.”

In August of 2008 Layla had another son. There were several interesting contrasts between the two experiences that she pointed out. She started her second story of birth by sharing that she, “warned each OB” at her later check-ups about her ‘high’ uterus. “I think it might have been a little annoying to them, but I just wanted them to be aware.” Next she noted that she carried her second child to 40 weeks. Her labor began when she woke up in the night to contractions. Upon arrival at the hospital a few hours later, bag of waters intact, she reports “I was admitted and my labor progressed.” She was fully dilated with no rupture of membranes within a few hours. “So the doctor broke my water” she says, “shortly after that, labor progressed very quickly.”

For her second birth she again reported a desire to “try it naturally,” but that she was again “open” to the epidural. She reported that her labor and delivery nurse was wonderful. “The nurse told me that I was doing great and that she really thought I could do it. At that time, I think that’s what I really needed to hear.” In her original email she wrote, “My labor and delivery nurse was WONDERFUL!” As her son’s birth neared she stated that “things got hard and she thought about getting an epidural,” but knew it was too late. She said, “I pushed through and made it.” After the birth her nurse had asked her if she was glad she did it without the epidural,

I told her at that moment I wasn't sure, but to ask me later. Now I'm glad I did. It wasn't easy, but I had a better idea of how I was progressing because I could feel it. With the epidural I was completely relying on others to tell me how I was doing.

In between her two births she met a woman, who had experienced unmedicated birth and was supportive of it. Layla said this woman made a tremendous impact on her perceptions about her ability to birth and ultimately on her decision to try unmedicated birth with her second birth. Following her second birth she says she did not want to tell people that she had not used an epidural or other medications. She feels that,

They think I'm being all high and mighty. I'm not trying to say I'm better than anyone. It just seems like too many people tell me "Oh, you're crazy" or "Oh you think you're better than me" because I had an unmedicated birth.

She reported that following our discussion that day she wanted to call her friend up and thank her for being supportive. It was not until the retelling of her story, in the context of our conversation, that she realized what a positive and significant role that friend had played in her birth experience. And Layla felt it was important to thank her for it.

Molly's Story: My Triathlon

Molly read an article I had written as a guest post on a mutual acquaintance's blog about the history of cesareans and had left a comment mentioning her own VBAC²⁹. I realized I had not been seeking, nor had I yet interviewed, anyone who had a VBAC experience. I thought that I should ask her if she would be interested in sharing her story with me. I sent her information about my research and she was eager and willing to participate. A few weeks later she invited me to her home for a conversation.

Molly had what she called "a textbook pregnancy" with her first child, a son born in November of 2007. She did have one "blip" in her pregnancy, which was gestational

²⁹ Vaginal Birth After Cesarean (VBAC).

diabetes. Going into her birth she felt confident and ready. At 40-weeks an ultrasound was done to examine the placenta. With gestational diabetes the placenta can age beyond what might be considered healthy. She said that, she was informed that although she was only at the 40 week point in her pregnancy the placenta was looking like 42 weeks and an induction was her best option. Molly cried, pleaded, and begged for more days post 40 weeks before the induction. She truly wanted to go into labor spontaneously, as it was her belief this it was best; she also had wanted an unmedicated birth and feared the impact of Pitocin on her body and her plans. The doctor/medical staff granted her a three day reprieve from the induction. Her body did not end up beginning labor during that window, so she checked into the hospital to be induced.

Molly's obstetrician, at her request, decided to strip her membranes³⁰ as a first attempt to bring on labor. After several hours of waiting there was still not a steady labor pattern going and it was decided that Pitocin should be administered. At this point Molly was lying in her hospital bed, husband by her side, electronic fetal heart rate monitor strapped to her belly, sobbing. She was devastated. Seven hours later labor was really progressing, but Molly felt a lot of pain, because as she says, "I couldn't move around. I had to be on the monitor because of the stupid Pitocin." This immobility was extremely frustrating for Molly, "I'm a mover even when I have a headache or am in any kind of pain. I was really struggling with it. I sounded like a sailor on leave."

The doctor came to do a routine cervical check and while doing so stated, "uh oh," which as Molly describes, "Is the last thing you want to hear." The phrase prolapsed cord was never used, but rather Molly was informed that her baby had the umbilical cord in his

³⁰ A technique to induce labor.

hand and was pushing it forward. “At that point it was immediate, do not cross go, do not collect \$200, we went straight to the operating room. There was no discussion really.” It was a whirlwind for Molly and her husband. Her son, whose sex they did not know prior to his birth and who “had a double 9³¹ APGAR³² score and was perfectly colored, was presented to [her] and then taken from the room.” Her husband went with their new baby. Molly described feeling like she was “watching somebody else’s baby being born.” A few hours later, back in their hospital room, Molly was holding her new son in her arms. The doctor was examining her and Molly asked about a VBAC. Her husband and doctor were a bit taken back by this question, “they didn’t understand.” Molly said, “I was that serious. Even in my first moments with him (my son) I knew I had to have a VBAC.”

A week or so after her son’s birth Molly began to question what had happened. There were several conversations with others, her own memory of the experience and the context, as well as interesting comments from others that led her to become “suspicious of the necessity of the c-section.” For Molly a few things “just seemed fishy,” it did not all add up to her.

In 2009, Molly and her husband conceived again. They were living in a different town. The town their son had been born in was no longer allowing VBACs so Molly was pleased to be in a location that had more options for her. She found a group practice that indicated, “even advertised, that they took VBAC patients.” Molly was “approved” as a “good candidate” for VBAC and began seeing the doctors in the practice.

³¹ APGAR scores are given twice during the first 10 minutes of life.

³² Assessment of vital signs at birth; assessment includes respiration, muscle tone, reflexes, heart rate, and skin tone.

Despite their stance as “VBAC friendly” at every appointment, Molly was informed of the risks (not the benefits) of a VBAC and asked if she was sure this was what she wanted. Molly was “annoyed by this,” but recognized that “in our litigious society doctors just have to cover their butts,” so she was “willing to tolerate it.” She decided to “let their disclaimer statements go in one ear and out the other.” Molly was an informed consumer. She had located the research, she had done her reading, and she knew VBAC was a safe option for her. She stated that the only information that she truly wanted to listen to was that which applied to her individual body, her baby, or her pregnancy. She often found that the information (the risks) were overemphasized (sometimes in contrast to the research she was finding) and that it was rarely specific to her body, her pregnancy, or her baby. Molly said of the doctors,

If you are just talking about the general, I understand that, I appreciate that. I know you’re scared, I know you think someone is going to sue you. That’s not where I’m at. I’ve done my reading. I’m okay and if I’m not – specifically me – I trust you to tell me that.

Molly ultimately felt like people were trying to talk her out of her “VBAC hopes” the entire time.

Molly was again induced with her second child. She was having some high blood pressure – an issue specific to her – and so she checked into the hospital to begin induction at 40 weeks and 2 days. Stripping her membranes or breaking her bag of waters was not an option; Pitocin was all that was offered. “It was, ‘we’re taping into you with the Pitocin the second you get to the hospital.’” At one point during her birth she began to become “emotionally overwhelmed.” She was finding so many similarities with her son’s birth, the induction, the intense and close together contractions, some pain in her back. “I’m back to

that same point where I was with him and I thought my body can't do this. I can't do this, other women can, but I can't." Her labor was stalling. She discussed with her husband going ahead and having an epidural to help her relax; she thought it was a good idea. She valued the VBAC over the unmedicated birth. After the epidural was administered and started taking effect Molly started to feel like she needed to push. "It was like my body had just been overloaded and as soon as I was able to relax – to turn that off and listen – I said, I'm pushing right now!" Molly describes going from a stalled labor around 5 centimeters to complete within a half an hour.

When she first started pushing she did not know if it was real. The labor and delivery nurse was very supportive through the whole process and told her, "You're really doing this. You're having this baby." That's when Molly asked for a mirror. Previously she had said she did not want to be able to see; she said she is "not really a blood and gore person."

I want to know what's going on and I think some of that was that I had been building up to this birth since the minute my son had been born and I knew I didn't want to miss it. I want to watch myself do this.

Molly's husband runs marathons and does triathlons and she says, "This was my triathlon."

All of a sudden I was having a baby and it was just the most amazing and euphoric thing. The very first thing I said after the birth to my husband was, "I'm not done, I want to do this again."

Her daughter was born the day after her 30th birthday in February of 2010. Molly got her VBAC; feelings of personal fulfillment overwhelmed her. Since her daughter's birth, one year ago, Molly has been tackling her lifelong weight issues. She describes that having a daughter made her more aware of her need to set an example of health. Her husband has also suggested, and she agrees that her VBAC experience has been a major influence in her ability to finally tackle her weight; the VBAC has had a positive rippling through her life. She's lost

100 pounds in the past year. Molly is a quick-witted and clever woman who recognized the importance of being an informed consumer – and it certainly paid off for her.

Cassandra's Story: The First Moments

Cassandra was introduced to me through a friend of hers who had heard about my study. She sent me a quick email to tell me she had heard about it and that she was willing to be a participant if I was still interviewing. We made arrangements to meet at a local coffee house in the next week. Cassandra is a tall and unassuming woman; her wardrobe and style draws little attention. Cassandra had her wavy brunette hair pulled back in a pony tail, something I was envying at the moment. I was still upset about a cut I had gotten over the summer and was desperately wishing my hair would reach pony tail length. We each ordered a drink and found a corner, which we hoped would be quiet and offer a touch of privacy.

Cassandra is a teacher and first found out she was pregnant at the start of a school year. Like many women, she was not going to share her news with co-workers or her students, so struggling with some exhaustion and morning sickness made “hiding” her pregnancy challenging. Cassandra spoke about “not loving pregnancy” and even worried that sharing that feeling and experience would earn her a label of “bad mom.” We talked for a little bit about this notion that she had brought up. She said, “There is no worse label than being a bad mom. Nothing could be worse than that.” What Cassandra unintentionally brought up was something I had been reflecting on throughout my research experience and that was the notion of being judged (and labeled) for our feelings and experiences. What Cassandra mentioned here was the connection she felt between simply saying she did not enjoy being pregnant and that this would lead someone to assume she was a “bad mom.” I had heard other women make similar comments about connections between their birth

experiences and fearing such negative labels about their role as a mother. Cassandra confirmed that she has struggled with this notion applied to birth as well, since she gave birth via cesarean. She agreed with me when I stated that “a social environment (between women) that encourages open dialogue and not judgment would be beneficial to our society.” She said, “We’re not allowed to have mixed emotions, or any emotion other than positive ones; if you’re upset it’s because you don’t love your child. That’s the judgment.”

Cassandra had been diagnosed with high blood pressure during pregnancy, also known as pregnancy induced hypertension (PIH). Towards the end of her pregnancy she “didn’t know if they [the doctors] were going to put me on bed rest.” Cassandra ended up not having to be on bed rest, but did her labor induced due to PIH. She stated that, “At some point, I don’t remember when, I got the epidural.” Unfortunately for Cassandra the epidural did not last, it wore off after a few hours. She said “They tried a lot of different things to get it working again, but never got it. It was great when it worked.” Cassandra said, “They never did say what went wrong with it.” After pushing for around 2.5 hours Cassandra said she “wasn’t progressing and they recommended a c-section. At that point, I was just like whatever it takes.” I asked if she felt the cesarean was necessary. She stated, “It wasn’t an emergency, but I felt it was necessary, I wasn’t making any progress.” Cassandra says she “was fine, it was worth it, he needed to come by whatever method necessary.”

Due to the fact that Cassandra’s epidural had not been working, she was put under general anesthesia (unconscious) for the cesarean. “It was frustrating,” Cassandra said in regards to having to be unconscious for her son’s birth. Unfortunately, because of the general anesthesia Cassandra’s cesarean was labeled as higher risk and therefore her husband was not allowed to be in the room with her. He was able to look on through a window and

once their son was delivered he left his vigil at her window and went with him to the nursery. Cassandra described that she felt “it was really hard for him to not get to be with me and then to have to choose to stay near me or go with our son was hard.” For Cassandra “The worst part was being completely under when I had him. I didn’t get to have that moment to first see him. Ya know, that moment that you’ll remember forever. It was painful for me – emotionally.” It was “two and a half hours later” when Cassandra first got to see her son. She reported that she has always been “obsessed” with the photos her husband had taken of her son in the nursery; “the moments when the nurses were cleaning him up and giving him a bath, because I didn’t get to be a part of those moments.”

Despite her sadness and frustration about having to be under general anesthesia for her son’s birth she continually stated that “it was so worth it.” Ironically Cassandra herself was born via cesarean birth in 1978. She had been in a breech position and therefore was delivered via cesarean. She said, “It was almost like foreshadowing. I never thought anything negative about a c-section, because I had been a c-section baby and I turned out fine.” Cassandra even said that she felt as if her mother was preparing her for any outcome, even a cesarean birth. She said, “I was not concerned about a c-section. I knew the baby was going to come out how is best.”

We began to circle back to our earlier conversation about judgment and support issues when Cassandra mentioned others reactions to her birth. “Should I feel guilty for a cesarean? I don’t feel guilty, should I?” She added, “That’s how it needed to happen. Everybody’s healthy, that’s the ultimate goals so it’s all okay.” Cassandra said that she was “surprised” that so many people were interested in “why” she had the cesarean. She

responded, somewhat angrily, “Is it any of your business why I had a cesarean? Should it matter, the baby is healthy, so who cares.”

Cassandra mentioned some concerns about having another child because of her experiences with her son’s birth. She anticipates that she will likely have another cesarean. Her reason for this was because the town, which she lives in, does not offer VBAC as an option and she does not want to have to drive to another town to give birth. She says, “I know that’s a silly reason.” She worries about “having to go under again” and “not being able to experience the first moments of my baby’s life.” She hopes that for any future children, which may have to be born via cesarean, that she will at the very least be able to be conscious for the event.

Lily’s Story: Crunchy Granola

Lily responded to my recruitment flyer which she saw hanging in the exam room at her OB/GYN clinic. She sent me an email telling me that my project sounded “interesting” and she would be a willing volunteer to participate. After sending her some more information about the project as a follow-up email, she was still willing, so we made plans to meet in my office for a lunch chat (Lily is also a student at the same university).

When Lily stopped by my office we had no trouble starting conversation. Like all my interviews I asked Lily to share her birth story with me and she did not hesitate to jump right in. She was very forthcoming and friendly. She was more than willing to talk about the subject matter; in fact, she shared specifically that she did enjoy talking about it, very much.

Lily defined herself as somewhat of a reformed hippie, “crunchy granola,” she said. However, to be honest, I would never have picked this particular label for Lily; to me, her appearance was like that of any other ‘mom-friend’ I know. She was casually and

comfortably dressed in a manner that did not draw much attention. Lily had moved to the area from the northwest coast and had formerly, as she reports, been a woman who did not shave her legs and even managed an organic health food store. Lily offered this background as explanation for her plans to have an unmedicated birth. In fact, the way Lily describes it she “knew” she was having a “natural” birth; there was no discussion of anything else. She never mentioned being “open” to “trying” labor and birth without pain medication to “see how she felt,” as other women participants had described. No, for Lily it was a sure thing, medications were not even mentioned. Simply put, she believed in birth and in her body and had no hesitations about her ability to accomplish the task ahead – labor and delivery.

Lily received her prenatal care from a local midwives group, something that she described as a very intentional choice. She was aware that during her actual birth she was going to have to “roll the dice” as to which midwife would actually assist her during delivery. However, during her pregnancy she saw one specific midwife. “I really had a real relationship with [my midwife], I trusted her and her opinion,” Lily said. When the 40-week mark in Lily’s pregnancy came and went, she turned to her midwife for suggestions. Lily knew that talk about induction and “remedies” for her post-dates pregnancy would be coming and she wanted to know what she needed to “take seriously” and what she “should do and should not do” when it came to the conclusion of her pregnancy.

“I had been having contractions for over a week when I was past the 40-weeks point, but they were never real. It was actually starting to get really frustrating.” Lily’s mom had come in to town around that same time; she had planned to arrive to help with care of the baby, “but she made it before the baby got here.” Lily actually thought that having her mother in town for the birth, as a support person, was a good thing. However, she was going

to “default” to her husband as to his desire for who was going to be at the actual birth. “I knew that my husband wanted it to be just us for the birth and I was fine with my mom being there or not, so I left it up to him.” Her labor finally began one afternoon while she was at the grocery store with her mother. “I started having contractions, but since I had been having all of these not real ones for so long, I thought nothing of it,” Lily shared. “It was funny though, because my mom started getting excited and I just said to her, it’s nothing, they are not real.” Lily reported that she was starting to get resigned to the fact that she was going to end up with an induction. She said she did not want that, but felt that was what was going to happen and she “didn’t want to dislike her birth experience,” so she started to accept the idea so she would not be “angry” about it when it happened.

All through dinner her contractions, still of the assumed “fake” variety, kept up and her mother continued to get excited. Following dinner Lily went upstairs to use the restroom and her bag of waters broke. She yelled down the stairs, “either my water just broke or I peed everywhere. I don’t think I peed everywhere.” Not long after Lily decided she wanted to go ahead and get to the hospital, her husband decided her mother should come with them. While checking in Lily was asked to sign release form for an epidural. She informed the nurse, “I won’t be having an epidural so I don’t need to sign that.” The nurse suggested that she needed to read it and consider signing it, “just in case.” Lily told the nurse “No thank you.” Following the completion of check-in the same nurse told Lily that she would “be back in the morning” at which time Lily would, according to the nurse, “have her baby.” When Lily questioned her about this the nurse informed her, “You’re not going to have that baby before tomorrow.” Lily was upset about this type of negative comment. She said, “I

was in a good spirits, happy. And I was just like, F you, not cool.” Lily adds, “Apparently you can’t be happy when you are in labor. Then [the nurse] left so it was okay.”

Lily decided to labor in the tub for awhile at the hospital and then eventually she felt an urge to push. She describes that she felt like she had to have a bowel movement; she was frustrated that “No one told me that’s what pushing feels like.” Her husband went to tell the midwife and his mother-in-law about Lily’s feeling and “just like that I was scooped out of the tub.” Prior to this Lily describes that “the midwife was almost invisible, in a good way. She would come in to the room, stand in the corner and watch, I was okay, so she’d then leave.” The midwife now stepped in and said she wanted to perform a cervical check to be sure there was no cervix left. This had been Lily’s first cervical check and she was complete at 10 centimeters. It was 1 o’clock in the morning.

During pushing “I used a lot of different positions,” Lily said. However, at some point there was some trouble finding the baby’s heartbeat, so Lily was asked to lay in the bed to ensure they could easily check on the baby. After some time Lily said, “I don’t want to do this anymore, I’m done.” She recalls that, “someone laughed at me saying that.” Then, “All of a sudden the midwife said, ‘Reach down and pick up your baby.’ And there she was-- eyes wide open and we were all goopy all together.” Lily added, “Then we had a baby at 2 in the morning.” At some point in the next morning the negative nurse from the night before did come back. Lily said, while laughing a bit, “She didn’t stay long.” Then she added, “And I did it without the epidural too!”

When Lily and I worked together to edit this document she added some interesting clarifying points in her story, the first being the perception and expectations she had about birth based on her own mother’s experience giving birth to her. This was something that we

discussed during our conversation, and others have noted as well, as significant. Lilly reminded me that from her own mother's experience she knew birth to be not a great big deal, "it was the way it was." She stated that it was something her mom "had done, not in a big, heroic sense," it was "just birth." Lily emphasized during our reviews that this perception and also the low interventions and support from her midwives impacted the way she approached her birth experience. She stated "I assumed it would hurt" and she "didn't have some freaky level of pain tolerance," but that she knew she could do it and she felt supported in this. This perception and the support of this perception, from various sources, had a major impact on Lily's experiences and we discussed the notion that it may be a more important concept (perception and support) than some might give credit to.

Dr. Steven Reid: My House and My Horse

Every interview, every conversation, that I have experienced throughout this research process has influenced me personally and hence the "outcome" of this project. However, my interview with an obstetrician might be, by far, the most memorable of all. I sent letters (appendix B) to local (50-mile radius) professionals (obstetricians, midwives, doulas, nurses) to describe my research and to request their involvement in it.

Two days after my letter had been sent I received a phone call. "Hello, this is Mandi," I said. "Yes, Doctor Reid (pseudonym), I'll do it," came the response on the other end of the line in a very short and terse tone. To be honest, I had to take a second to process what this call was referencing and if some doctor was trying to reach a patient and dialed the wrong number. I stumbled over my words for a moment, and likely sensing my moment of confusion he said, "Your letter. I'll do it." Of course, I was relieved to, not only understand what this call was about, but to also have a professional participant. He stated he could meet

on a Friday, but not the coming Friday and that I should email him and provide him with the details of our meeting location. I felt I had to keep him on the phone long enough to get an idea of a time of day and type of location and his email address. To the questions, he simply responded that he wanted to go to a place where he could have a cup of tea. The call lasted less than one minute and was my first experience with Dr. Steven Reid.

I immediately went to my field notebook and began to write about how the phone call felt impersonal and awkward to me and about the length of the call. I also noted that I, for the first time in this research process, felt very at the mercy of one of my participants. I noted this simple because one of my goals in this process (feminist goal) was to attempt, as best I could, to create a “level playing field” with my participants – to try to address, and do away with, the natural hierarchy of the research relationship, meaning simply that I had been working hard to recognize that I was the one coming to my interviews with *the power*, and attempting to reduce this feeling for participants. However, it was important to note that with Dr. Reid, it felt clear to me that he was the one with the power – doing me the favor – of participating in this research. Although, I might not disagree with this by any means, it is worthy to note that this is where my relationship with him started – with a sense of powerlessness.

A week later we met at a local coffee shop to discuss my research. In the letter I had sent to Dr. Reid, I also sent my research summary and a flyer (see Appendix P). From the way the conversation started, it appeared he had read some, if not all, of the material I had sent. He sat down and before our handshake and brief introductions were complete he began speaking. I did not yet have my digital recorder turned on when he began to speak.

In my reflections following my conversation with Dr. Reid, I noted how shocked I was that I had appeared to have recruited the most “textbook” and stereotypical male obstetrician I possibly could have for this project. I found that he was a very kind man, certainly, and undoubtedly, an asset to my research project, but his demeanor was (to me) unequivocally that of *the doctor* – the all-knowing expert in charge of the situation! He did not fail to have a response – *the* right response – to my questions. In fact, I asked very few questions; he simply spewed out his knowledge to me and I was to be the lucky recipient. He often used expressions and language to describe women or childbirth in a manner which was negative or belittling. He referred to himself several times as the “protector” of one thing or another (birth, the woman, her baby, the woman’s sex life). On my interview summary sheet (see Appendix B) I asked myself to describe each interview in three words. The words I used to describe my interview with Dr. Reid were, “arrogant,” “wow!” and “honest” in that order. My conversations with him were undeniably enlightening for several reasons. Moreover, despite my feelings about his textbook nature, he truly did provide me with genuine insight and, by my experience, a very honest and sincere view of his professional work and experiences – a valued gift to me and this project no doubt!

The dominant theme of our conversation was undoubtedly that of liability. Dr. Reid made it very clear, in fact he stated, “Let me make this perfectly clear. On a good day – a good day – I hate lawyers.” He went on to state that when he was in school he wanted to be a doctor or a lawyer, but “I wanted to keep my soul, so I became a doctor.” Furthermore, he stated that fear “drives everything” he does. Specifically, he was talking about his fear of being sued because someone “has a bad baby.” He reported that if he is sued the only thing the lawyers cannot take is his house and car. “Your house and your horse, that’s all you get

to keep. That's why doctors live in big house and drive expensive cars." He added, "We have to think legally because the lawyers have made us."

Dr. Reid explained that "Women see a c-section as a way out of difficult pregnancy, lawyers agree, so that's a pretty strong incentive to do c-sections." Legally he reports that, "as long as you did a c-section, you did everything." He added that "You get paid more for c-sections, why in the world would we delivery somebody vaginally then?" The topic of cesarean birth was also quite dominant during our conversation, despite my efforts to redirect the conversation at times. He indicated that he believes women see a cesarean as a sacrifice they are not only willing to make for their child, but ultimately one they desire to make. "Women are willing to allow us to beat them up, in order to bring the child and get the outcome. They're looking for. . . it becomes a sacrifice." Later I asked him about his experiences with how women feel about their births and other issues of empowerment. He responded,

When you are talking about empowering women. This is how women are expressing the power relationship; it's "hurt me save the child." When you look at the natural side...that's attractive to some women, but what's more attractive to most is "save my child."

Later, when I again tried to address his thoughts about whole-person care he stated,

As far as holistic approach there is a bias in medicine that women who want holistic approach are more interested in themselves than their babies. Women who are more interested in the baby than themselves would opt naturally for a c-section.

He went on to discuss that when he makes a decision about suggesting a cesarean he is thinking about "defending the [monitor] strip³³ in court," "putting my kids through college," "having to drag my wife and family through a lawsuit," and the belief that, "there is

³³ Electronic fetal heart rate monitor outputs a paper strip.

always somebody who will testify against you.” He reported that these are some of his thoughts when he is “sitting around in the doctors lounge, knowing I’m going to have to cut her” because he “is going to get a good baby out.” He feels that it is “not fair to her, but it’s fair to the rest of the system” that because of these thoughts and issues he is going to “have to cut her open.”

I asked him about how he deals with informed consent in these situations. I stated that what he described sounded like it was a situation in which there was no clear emergency or inherent danger, but a decision which was based more on ensuring his own protection. To this he immediately smirked and stated,

Informed consent is easy; you can always get informed consent out of her. It’s all in how you present the data. I talk people out of their body organs, trust me, I can talk you into a c-section. It’s a done deal; no one is going to stand up against that kind of pressure. You can twist people’s arm (puts his arm behind his back) to get whatever you want.

He went on to add

I can live with myself committing an injustice to her and giving her a good baby versus not doing it and putting my wife through (pause). I’ve got to see my wife every day. If this lady doesn’t like my care she can go to someone else next time.

Later I again tried to address how he handles women’s emotions and the way in which they internalize their birth experiences. I stated that for example, a woman may feel sad or even defeated that she had a cesarean. He quickly responded, “Why are [women] feeling defeated? If you had a healthy baby and a healthy mom you won. This is a pass fail class. There are no medals being handed out for those who endured the most pain.” However, later he also pointed out that “60-80% of women get post-partum blues.”

During our chatting he also spoke about birth plans a bit and indicated that they have to be treated like a legal document – because, again, the lawyers make him. He states that he

tries very hard to meet the goals established on the birth plans, but has found in his experience that women often do not even know what they have written on them. He said he once went to a patient after her birth and said, “I tried really hard to do all of these, but this one, I just didn’t get. The woman looked up at me and said, ‘Oh that, I just got that off the internet.’” He stated that birth plans have come about as trendy right now because “women are trying to take back control” of their birth experiences. However, he also mentioned that “There is a joke among obstetricians, that the longer the birth plan the faster the c-section.” A final note on his philosophy about birth plans is that “(I) know most of this stuff -- you don’t have to instruct me. I know how to deliver babies; you’ve read one book.”

One thing that I did greatly appreciate hearing Dr. Reid say in several different ways, several times over, was the belief that “There is nothing inherently wrong with the birth process.” He also stated that “90-95% of births go just fine;” of the remaining 5-10% he says he is able to predict 90% of what will go wrong, but “it is that remaining 1% that just comes out of left field.” He also spoke about the impact that “medicalization of a normal process” has brought and the influence specifically of medical language and pathology on shaping experiences. He shared, “We’re doctors; we don’t talk about or remember what went right; we talk about what went wrong. That’s the language medicalization brought. Then women hear it and talk to their friends and so on.” He stated that he believes this language, through medicalization, has increased fear.

When I asked specifically about what changes he has seen during his professional career in maternity care, he said, “Women are operating on fear.” He also added that there is a “team approach now, in which everyone has a voice” opposed to when only doctors were in charge. In his experience he believes that both the nurses and his women patients are not

hesitant to speak up and use that voice to question him. He again reiterated that he spends a significant amount of his time “trying to convince [patients] that it’s going to be okay. A big goal of my job is to reduce fear.” He believes that “We are all going into this terrified, and so now you’ve also got to deal with my fears about how I want to manage these pregnancies and deliveries.”

In conclusion, I asked Dr. Reid what he thought about the future of the maternity culture in America, specifically what changes he anticipated seeing. He simply responded, “You’re going to see c-sections on demand increase.” He reported that this is because, “Women don’t want to stretch out their vagina and they want to avoid repair later.”

Jessica’s Story: This is Top Secret

I met Jessica at a childbirth education workshop. I attended as a learner and she was the instructor. My purpose and intention as an attendee of this workshop was not research-based – I was not seeking a participant. However, it was not long into the workshop that I found myself feeling overwhelmingly compelled to jot down field notes, just as I would following an interview or other research-related experience. To be honest, I was somewhat relieved to hear Jessica speak to our small workshop class of nine. I was relieved because her comments and statements were not coming from any conversation or prompting that I had provided, as I may have if I were “interviewing” her as a participant. In fact, Jessica had no idea I was a graduate student researcher or any knowledge of my research interests. She knew I was “Mandi,” workshop attendee headed towards certification as a childbirth educator. These facts made the information she was sharing with the workshop audience and the notes I was taking even more genuine and pure to me than if she had been an *actual* participant.

To be sure, the things that Jessica was saying were certainly resonating with me. The statements she made were things I had been hearing from others and that I was reading in various texts such as “A lot of women are traumatized by their births,” and “The preventable hospital deaths we have in this country are equivalent to a 747 crashing every other day,” “Healthcare providers are not the enemy, I think it’s a system issue in the U.S. right now,” and also “There is a spirit moving across this country trying to take birth back and make it what it is supposed to be.” However, it was not until the lunchtime break during the second day of the 16-hour workshop that I finally decided to approach Jessica and tell her about my research. After some debate for the first 12-hours of the workshop, I had decided that the information she was sharing, and her experiences, were far too rich to deny. I wanted Jessica as one of my professional participants.

Jessica has been a nurse and childbirth educator for over 30 years. She speaks with a soft, gentle, and patient tone. She is overwhelmingly motherly and nurturing to me; some might say she is the embodiment and essence of *a nurse*. Jessica has a kind of goofy sense of humor, something I relate to that of a grandmother. However, despite these more genteel features and traits about Jessica, she is a fierce bloodhound for research and evidence-based practice in maternity care. She is extremely intelligent and not afraid to challenge the process of practice in the U.S. She believes, and preaches, that education and good information is every woman’s right during her maternity period and she aims to provide this service to all.

After sharing with Jessica about my research and asking if she was interested in participating we agreed to communicate via email to arrange a time for the actual formal interview. My actual interview with Jessica was my first, and only, computer mediated one.

We used the Skype internet chat feature flawlessly! We chatted for just over an hour and the conversation was recorded on my digital recorder, just as all others had been.

The dominant theme of our conversation was the “top secret” nature of what Jessica was sharing with me. She used phrases like, “That’s a big secret,” “I’m not supposed to talk about this,” or “You can’t say these things” several times during our conversation. The fact that she used these types of statements and also frequently mentioned a concern about her anonymity made me believe that she was being very forthcoming and honest during our interview about her experiences.

The “drum” Jessica says she would “beat the loudest” is that of reducing inductions before 40-weeks. She has seen these inductions rise significantly during her tenure in the field and she firmly believes there is evidence to support that this is a major deficit for both mom and baby when this happens. Most importantly she believes that the breastfeeding relationship and the promotion of bonding that comes from that relationship is negatively impacted. Babies born before 40-weeks often have not developed a strong suckling reflex and as a result may struggle at the breast.

Jessica spoke about her early years on the labor and delivery floor as a new nurse in her 20s. She stated that at that time, late 70s, fathers or any other support persons were not allowed in the delivery rooms (in her hospital) and it was very “doctor-centered” practice. She stated that she “knew in her soul that things were supposed to be different.” She indicated that, “Nurses are not being trained in normal labor” (then or now), but rather trained in “management.” “Doctors have the final word and patients and nurses alike are not to question this.” She shared that the labor and delivery nurses talk about this philosophy and that they “know it isn’t right,” but there is little they can do to change it – “it is a bigger

system issue.” Although some things have changed since she first became a nurse, “mainly husband and support persons being allowed in the delivery room,” she still sees the same overarching philosophy of medical-management for the most part. One topic that dominated a lot of our conversation was the impact of the one-size-fits-all philosophy and the assembly-line, industrialized, manner in which women are being processed (*subjected to*) during their births. “It’s all about money, production, getting these women through; we need to know how to keep them on the line. We do not need them to know about normal birth.” Jessica stated that when she gave birth for the first time, in 1983, she was “put on a cart and wheeled from one room to another.” She said that she has heard people say that women during labor do not care about this because they are so “lost” in labor, but she vividly remembers feeling “ashamed” by that experience and was adamant that “a woman knows and she does care.”

Our conversations frequently shifted between the past and present experiences in birth and the ways in which they have changed – for better or worse. “I’ll give you a picture of what’s really going on out there on the labor and delivery floor,” she said. At present, Jessica stated that, “The mother has to meet what is normal for the mass number of women not what’s normal for her anymore” and went on to indicate that “standard procedure includes the epidural and Pitocin.” Furthermore, she said, “If [a woman] doesn’t meet criteria [the medical team] will intervene.” She elaborated on the criteria which she was referring to, and explained that for the most part this means a woman has to be progressing at 1 centimeter dilation per hour. This is often the same “progress” and rate of progress that is being referred to when discussing “stalling in labor” or “failed progress” She added,

They call it medical management, where the doctors take over and makes sure you get delivered in the 12 hours. In the old days labor for 36 hours was fine. Now they want you to have that baby in 12. Is this evidence-based? Absolutely not.

Two other interesting viewpoints that Jessica contributed to this research have the potential to be quite political and controversial – which is not uncommon territory for issues in maternity. One of her beliefs is that sex education classes are a potential source of fear for women. And the other belief is that women becoming obstetricians has changed the way maternity services are provided on the labor and delivery floor.

I think women are afraid of childbirth because of what they learned in sex education classes. Yes, teen pregnancies are decreasing because they are so afraid and that fear is staying with them. Birth was not shown to young women in a positive way, because the powers that be did not want them to get pregnant. There's a benefit, teen pregnancy is down, but at what risk – what horrible things have we done to get that?

She concluded by saying, “My husband says I cannot talk about that.”

Perhaps even more controversial is her experience and belief about the impact of female obstetricians. Jessica stated,

I haven't found any [labor and delivery nurse] who disagrees with me. When men were OBs it was better, but you can't talk about it. It's a hidden thing, the white elephant in the room, but we older nurses know.

She continued and again indicated, “It's top secret. It is so taboo, that we're going to pretend that it doesn't exist.” She described often “hearing female obstetrician's saying ‘Well I had [cesarean] and it was fine.’ There's no evidence-base for that.” Jessica suggested that this observation has to do with support systems at home for the working professional (female OB, in this case). She reported that, “[The female OB] comes to me and says ‘We have to get her done, I don't have childcare tonight.’” Is that for mom or is that for the OB?” She also went on to suggest that she believes women OBs are having more cesarean's because they do not feel safe, and one reason for this is that they know they are on display (referring back to the

assembly-line processing). Again Jessica added, “That’s a huge secret on the OB unit...you can’t talk about it.”

Similar to both Paige and Penelope (both CNM’s), Jessica also stated that “A mother will parent the way she was treated during birth.” She added that the hormones that are released during labor and birth also influence parenting and stated, “If the hormones aren’t there you just watch.” She spoke about the crucial importance of breastfeeding and the impact this has on bonding. She again made controversial comments about the current climate of the maternity culture and even argued that, “Why wouldn’t you want your country to breastfeed and why would you not want them to normal birth? Because you want them back at work.” In her recent experience she stated that many times she has heard new mothers state that they chose not to breastfeed specifically because they “do not want to bond with the baby, because they have to go back to work.” Ultimately Jessica believes that the baby and what is best for the baby is forgotten in the current practice of birth management. She fears that this is costing us, as a nation, far more than we may ever be able to measure. When I specifically asked Jessica what changes she has seen in her experiences in the past 30 years, she replied:

Choice has changed. The real issue is now moms don’t have a choice. You cannot have a non-medicated birth because you don’t have the nurses or doctors that have ever seen it and so they don’t know how to support it. Those days are long gone. You will not find nurses to know the words to use...the positions...the choice is no longer there for women. There is no choice. The nurse isn’t going to be there at that moment to say you can do it. [The nurse] is going to say, “Are you sure you don’t want your epidural now?” Because [the nurse] is frightened of natural birth.

Finally, she indicated that “medicalization has made it so that [nurses and doctors] don’t know normal birth.”

Overwhelmingly I felt that Jessica was crying out – even shouting – for the need for open dialogue about these concerns. She stated “How are we going to address the problem if we aren’t even going to recognize it?” When I specifically asked her what she believes needs to happen to improve maternity services to woman, she said, “We have got to have open dialogue about breastfeeding, hormones, the baby, and what is best.” She again mentioned,

I’ve been told over and over again, you keep your mouth shut. Don’t you be talking about this, but this is what I am hearing, this is what other nurses are telling me. This is what is happening on the OB units, this is what nurses are saying.

In order to see change in maternity services and in the culture surrounding the maternity period, Jessica believes it has to come from policy. I asked her if she thinks positive change is possible and she said she “does have hope.”

Penelope’s Story: Also Their Friend

Penelope was the first professional to respond to my request to hang my recruitment flyer in office spaces around town. She was supportive of this research and was also willing to be a participant. We communicated over email for several weeks and finally coordinated a meeting in her office, at a local clinic, after her normal business hours. I was excited to have the opportunity to meet with Penelope, as she is a midwife who is very highly spoken of in the community. I had heard positive things about her from female friends, participants in this project, and also doula clients.

Penelope is a tall attractive woman, who is probably much older than she actually appears. She wore a white lab coat, with her long dark hair draped over her shoulders. She both walks and speaks softly and gently. Her pace of both movement and speech is naturally calming and relaxing; however, it was challenging for me – being a naturally, fast-talking,

quick-moving individual. Simply to say, being with Penelope forced me to slow down, which I considered a good and positive trait.

Meeting with Penelope, in her office, was a strange and exciting feeling as I myself had previous been a consumer in the clinic years earlier. Being in the clinic space in the new context – not as client, consumer, or patient, but as researcher - was an interesting experience for me. I felt flattered to be invited behind the curtain, if you will. We met with her office door open and I felt as though there was awareness (perhaps caution) that others – her professional colleagues – could potentially hear our conversation. She seemed more reserved than perhaps she wanted to be during our chatter. At times pausing and thinking carefully about her responses, even looking towards the door, rather than giving a more “candid” response. This is not to say that I feel she was ingenuine, but rather I had a sense, from her expressions and tone, that she may have wanted to say more, but held herself back a bit.

For the past 16 years Penelope had been in professional practice as a certified nurse midwife (CNM) and prior to this she had been a registered nurse (RN); specifically she had served as a labor and delivery nurse (LDN) for 2 years prior to going back to school to become a midwife. Therefore, not considering her years in midwifery school or her other years as an RN, she has specifically been providing professional care for 18 years. The most poignant moment, for me, during our conversation was when Penelope started to cry when she spoke about not just being a midwife to her clients, but that she hoped she was also their friend. She stated that following any birth she attends, she will thank the woman for inviting her to her birth. She said,

They don't have to invite me, but they do, and that's really special for me. This is more than a job for me and I tell people – and I mean it – that I would do this job even if I didn't get paid.

Clearly her “job” and her role in the lives of the women she serves are very important to her and something she does not take lightly. Our conversation mostly centered on issues of support, psychology of birth (role of fear and anxiety), and changes she has observed during her professional tenure.

Penelope sees herself as a support to women during their pregnancies and birth, of course, but also talked about the importance of support from other sources as well. She noted a general feeling of an absence of this in women’s maternity experiences presently. She shared about a recent opportunity in which she and a fellow nurse acted as a doula for a client.

This past week I acted as a doula for a gal and either the nurse or I were with her constantly. To hear [the laboring woman] say at 6cm “I can’t do this anymore,” and then we went into the room and stayed with her the whole time and she never said it again.

She intertwined this support notion with psychological and emotional influences in birth as well when she added,

If you can just help her get into that zone where she just says I don’t care how long I have to do this I’m just going to do this until I’m done. [The woman] just has to get there, to that place in [her] head and once [she’s] there [she] can do it. It overcomes everything.

She concluded this story by noting that she “definitely can see a difference in the women who have doulas.”

Immediately following her sharing of this story Penelope began to address issues of change and the current state of maternity practice in her experience.

At the hospital now we have a new group of nurses, a lot of the older nurses who have been here for years and years aren’t there anymore. The younger nurses seem dependent on technology, they want everybody on a monitor, and they want everybody epiduralized, because it’s something they can control. The nurses can go

out of the room and know what happened while gone because [the laboring woman] is still going to be in the same spot [the nurse] left her.

Penelope added,

One of my goals is to work with the newer nurses and just let them be comfortable with birth, which they are not right now. They are afraid of it. They don't know what to watch for. They don't need somebody on the monitor all the time to know what the baby is doing, listen to the baby rate every half hour, you will know if something is up. You can just watch a woman and know where she is dilatation-wise if you have been with enough women. If that is going to be [the nurses'] calling or their livelihood, then those are things that they do need to know.

During our conversation Penelope also discussed the differences between the obstetric (medical) model and the midwifery model of care, which seems relevant to note in this context. She indicated that the medical model philosophy is that “pregnancy is a disease” and she does not believe this to be true, but it is the model in which new nurses are being trained. She added that, “Obstetrics is the study of the abnormal. So, if you are not sick then maybe someone who isn't so focused on the abnormal, like most midwives, might be an okay option.” She mentioned that there is some level of pressure, working in a practice with midwives and obstetricians to incorporate more of the medical-model philosophy of care, but not overwhelmingly so for her.

In discussing the significance of birth and the life-long impact the experiences have on a woman, Penelope stated, “If you are treated well [during] birth, someone mothers you, then you will be a good mother to your child. I think we are losing a lot of that when we talk about the medicalized birth experience.” Paige and Jessica, specifically, made other quite similar comments about being mothered during the birth experience and that connection to actual mothering post-birth. Penelope indicated that the current state of the maternity system, and specifically the hospital, is not set up to “mother” woman during their births, but

rather to be “treating superficial things.” Instead of asking what a woman’s pain is, Penelope believes that asking how the woman is feeling and more importantly what can be done for her to make her comfortable would be more emotionally supportive and encouraging – to nurture women and not to manage them. However, Penelope was clear when she stated, “We can’t do that at the hospital.”

A final note that Penelope offered regarding her experiences is her belief that “people are not in touch with emotions” and this can be a deficit in birth and beyond. She addressed the need for more open and honest dialogue and validation for our feelings and emotions. She made mention of the fact that many woman she sees, even when she can tell there is fear and anxiety, either will not or cannot address those feelings and it does impact their birth experiences. She spoke about a fellow midwife whom she had worked with who had an emergency cesarean. She stated that this midwife often discussed a lack of ability to find a social space to grieve her experience but that it was something she felt was necessary. Rather those feelings had to be held inside and suppressed, which greatly influenced her being – as both woman and mother. Penelope believes these emotional issues are significantly interwoven with the notion of support. She feels that women need to be more supportive of each other during their birth experience, and most certainly in parenting. She believes this support would reduce fears and in turn improve women’s experiences. However, she feels the current system is not set up to create or promote this type of social support. This is one thing she mentioned she would like to see changed as she believes it would have a ripple effect to impact women in a deeply and profoundly positive way.

Paige's Story: One Woman at a Time

I was introduced to Paige over email. A doula acquaintance of mine, to whom I had sent my recruitment information, provided me with contact information for other professions she worked with. One of these contacts provided by my acquaintance recommended that I get in touch with Paige. I introduced myself over email, shared how I had come to have her information, and attached my recruitment materials. Paige was more than willing to sit down with me and chat about my research project and the topic of birth in general. We made arrangements to meet a few weeks later at a local café.

I had heard Paige's name before in some of the professional circles within which I circulate but had never actually met her. I was aware that she worked with one of the few local homebirth midwives but was not sure in what capacity. I found out that Paige was, in fact, herself a certified nurse midwife (CNM) and also an instructor in nursing at a local college. Due to the fact that there are so few homebirth CNM's in the area, I will not share anymore details about Paige professionally or by way of appearance, to protect her anonymity. I will however share that I was flattered at Paige's willingness to meet with me and share her experiences as part of this research. Beyond this I can say without a doubt that my interaction with Paige, other than emails, which lasted only an hour and a half one Saturday morning had a profound impact on me personally. Not only did my meeting with her and the insight she shared inform this research, but it significantly influenced the way I thought about my research and about the world around me. I was changed because of my meeting with her that day and for this I am truly grateful.

Paige started our conversation by sharing with me that she believes "fear and childbirth are inherently linked, since the beginning, but now there is a very unnatural fear

that woman have.” This led quickly into a discussion about community and the concept of a village (i.e., it takes a village). She added that “women fear the lack of community they feel -- not fearing a bad outcome, as much as a fear of losing control. Having things done to me that I don’t understand. The fear of being a mom.” Paige believes that women, “hold fear in their heart and don’t talk to each other about it” and this is significant. This, according to Paige, this is the “cost of the loss of community.” She adds that, “It takes a village. You don’t know what that means until you’re pregnant. And we don’t have a village anymore. Women feel a need for this and it’s not there.”

Paige addressed her feelings that during pregnancy and birth, at present, a woman is put in a position to give up

Her power and her decisions . . . they did to her . . . she was delivered, she doesn’t go to a hospital and deliver, she is delivered. The current dominant model of care is disempowering to the self as a mother, a person, and a citizen.

She went on to describe her philosophy and approach to birth and how this then shapes the way she practices in offering maternity care to women. “Birth is what it is,” she started. “It is a transformational, caterpillar to butterfly – metamorphosis – to a whole other being. So how do you take that transformation? Go inside, listen to intuition? Or follow a prescription?” Her philosophy is to support and encourage women to go inside and trust their intuition. She believes that “women are insanely brave,” but that often they have spent a significant part of their lifetime being convinced otherwise. The trait is suppressed and therefore forgotten. Paige takes the job of encouraging women to recognize this trait and their inherent power very seriously. Like others, Paige also noted the “psychological and life-long impact” that childbirth has for a woman. Therefore, honoring that experience – the transformation – is something that Paige considered to be of high importance.

Paige shared with me, briefly, an experience she had as a maternity patient 13 years prior when she had her first child. She was a travelling labor and delivery nurse when she was pregnant. She knew where she was planning to have her baby, her “home base,” and she immediately made contact with the local clinic and professional providers there. Paige explained her job and her professional credentials with them and asked that they take her as a patient. She suggested they send her their protocols and she would provide them with the necessary test results, vitals, and so following the protocol. She was refused. “They wanted to put me in the correct box. To them I was just one big liability,” she described. Paige added that she, “thought I could make decisions for myself, I thought that I had control because I had a birth plan and because I was a labor and delivery nurse.” Instead she found herself labeled “high risk” on her chart, a “NO DOC,” because she had not had consistent prenatal care with them. She asked me, rhetorically, “Does that make any sense? What kind of a fucked up system are we in?” Paige used this example to highlight the systemic power structures at play in birth practices and the impact they have on women and their babies.

These personal examples drifted quickly to the two things, which Paige specifically believes, are “missing” in the present “medical system” which are “informed consent and empowerment.” When it comes to informed consent Paige believes it is necessary to ask questions. She states we should – not only in birth, but in life – “question yourself constantly and question others constantly.” She spoke about her desire to help her students understand what informed consent means and the importance of questions, not simply as practitioners, but as citizens.

The majority of our time together was spent talking about issues of support and the impact of the loss of social support in birth. We spoke for some time about the ways in

which other women talk to each other and do not talk to each other about birth and the ways in which women often feel socially judged in birth. Paige brought the conversation around to paint a picture of individualized care. “We are talking about this mom and this baby, not all moms and all babies. One mom and one baby at a time, that’s it. That is it.” Paige believes that it is important to “encourage dialogue” about what each woman – each mom – feels. To allow her the space (emotionally) to define for herself what her experiences meant to her. She shared that she feels it can be dangerous and detrimental to promote the silencing of these feelings (the good and the bad). We spoke about the common expression “Baby is healthy and mom is healthy so that’s all that should matter,” as one way in which women are often silenced, and often by other women. Paige asks, “Everything went good, why do I not feel good?” Instead we need to promote a conversational space for each woman to explore what she feels and why she feels it. “That’s it,” Paige said again. “Not what she should feel, what someone else says she should feel, but validating her feelings and honoring her with this.” The clinic she works in attempts to create this emotional and social space by holding monthly “birth circles” in which groups of women, pregnant clients and those who have just given birth, gather together to talk about what they are thinking, feeling, and experiencing. Paige shared that her goal is that woman will “bring [their feelings] raw,” because “this is a safe place and I’m a safe person.” This is her vision of a village. It may be a small village, but it is a village no less.

We discussed social and emotional support and the broad impact of the lack of these types of support. Paige talked about the support needs that she also has as a provider. She discussed the “messed up system” that we have in America that often leaves her having to sacrifice herself for her clients. She shared,

When I've been at a birth for 40 plus hours and I'm just beside myself with needs that have been unmet, this needs to not happen. We need to have a village, a community of safety and a recognition where everybody is on board with things like informed consent and empowerment.

Paige attends home births, and as I mentioned before there are very few CNM's practicing homebirth locally, for various reasons. What Paige was addressing here was that the lack of community puts the midwives in a position of suffering for support as well. If a woman has to be transferred to a hospital Paige and her fellow practitioners are not able to stay with that patient and ensure that there is continuity of care and that the woman is treated in the same manner as she would have been in her own home. When Paige and her colleagues have life events occur, or are simply exhausted themselves, there is not "a village" of women they can call on to "take over" and ensure this woman is given the same level of care they would have provided. Paige states that it is "innate in us, as women, to be there for each other," but socially we are not accepting of this and we all suffer because of it.

One concept that Paige brought up that really impacted my personal thinking was when she stated that we "all need to stop bringing our own stuff into birth." She emphasized the importance of not defining for a woman what her feelings or her experience "should be" and therefore "should mean" to her. It is her belief that this is for each woman to decide and define and we should all be very cautious of any tendency to do this. In Paige's experience women "don't feel they can talk about not feeling 'okay' because they are socially met with responses of 'what's wrong with you?'" She added, "We, as a society, tend to put labels on people, instead of validating them." Paige asked, "What impacts a woman's birth more than how she feels about herself, her partner, and her baby?" Statements like, "You're fine, everybody goes through that," can have a tremendous impact on how a woman feels. "Just

because everybody goes though it doesn't mean I'm fine or okay. . . It is a big deal to me.”

Paige would like to see that “each and every person be empowered enough to define for themselves ‘all that matters.’”

Part II

The Modern American Birth Experience, Presented In Eight Themes

Prior to reading the following section I want to remind the reader of the perspective that I used during the analysis of my interviews. Because this study is a feminist critique, the women's experiences are the primary focus. Beyond this, experiences in which marginalization or silencing of women's voices has occurred – or potentially occurred – are highlighted. This does not mean that all similar or parallel experiences, holistically or in part, are marginalizing or disenfranchising. Rather the aim and focus of this study was to explore whether or not those elements were present in women's experiences (specifically in my participants' experiences) and what this might mean for other women. The critique element of this research simply means that within those highlighted areas, as I offer questions as to why this marginalization or silencing might be occurring, I challenge the thinking (my own included) and the process of how we (Americans) do what we do.

It is important to remember that, as with any study, the presented results are often only a fraction of the data (a snapshot) that has gone through several rounds of analysis and refining. It was a great challenge to try to report women's unique and extremely diverse experiences in a holistic-like manner. Therefore, what you are about to read is not everyone's experience and it is not the whole picture, but rather it is a represented portion of many unique and diverse experiences filtered through a feminist lens. What I intend to present here is not a unified image of women's pregnancy and childbirth experiences, but

rather to shed light on *some areas* which often are not addressed, to open a dialogue, and to challenge our thinking and doing surrounding birth in America. The goal here is not necessarily agreement, but rather to promote critical thinking about what I present. My sincerest hope is that at the conclusion of this reading, not all readers will agree but that all will instead find themselves with many more questions!

Theme 1: I'm a Person, Not a Chart

There were an overwhelming number of statements and stories in which women described a desire, and even an expectation, for individualized care. My understanding is that although women appreciate (and like) their providers knowing their names, they do not feel this is representative of receiving individual care. Isabella described her interaction with different providers³⁴ during her pregnancy and stated, “It was more of a person-to-person experience [with the midwives] than a doctor-patient experience, which I appreciated.”

Isabella also stated,

the doctor is very medical, and I understand [the doctor] has to look out for [him/herself]...they don't want a lawsuit, I get that, but at the same time if they know me as a person – not just medically – if you know me psychologically, spiritually, if you get the whole me you're going to understand me. I'm a person, not a chart.

Similarly, Molly also stated,

If it's a situation that is specific to me and this pregnancy I was willing to listen to that and will do that, but when [the doctors] were just giving me general statistics, not specific to me, I was not interested.

³⁴ During her pregnancy she was seeing an obstetrician (OB) as her primary provider. Due to schedule conflicts she needed to make appointments with midwives (MW) who were in the same practice with her primary provider.

On the flip side there are the professionals who also indicated that individualized care is something they are not able to truly provide, but not for a lack of wanting to. They gave two reasons for their inability to provide individualized care, (a) liability and (b) training.

Liability is one reason that standard – not individual – procedures and routine – not individual – protocols are put in place in clinics and hospitals. These standard procedures and routine protocols exist as a means to protect the providers and hospitals from lawsuits and are required by malpractice insurance; they also assure that the providers and hospitals do certain prescribed things in a certain prescribed way, no matter who the patient is – no matter what the patient’s individual needs might be. This is not to say that these standard procedures and routine protocols are not potentially beneficial to the women as well, but simply to highlight that this as one reason women do not receive the *individualized* care they desire.

Training is the other frequently noted consideration professionals cited to explain why it is difficult to offer person-to-person care. Providers are trained to know standard procedures and routine protocols and to follow them. Several professionals mentioned this as frustrating and not representative of their desired way to practice. Jessica summarized this issue with the statement, “The mother has to meet what is normal for the mass number of women, not what’s normal for her anymore.” She went on to say, “nurses can’t look at individuals; every woman must fall into a category. Nurses don’t have the training to treat individuals. . . .The rule is you follow the hospital policy over the individual.”

This assembly-line-like protocol has been described as, and critiqued as such, a one-size-fits-all approach to maternity care. Paige added, speaking of her own pregnancy experience, that she felt “they wanted to put me in the correct box” rather than to see her as

unique. Dr. Reid also mentioned his “rules” for birth and indicated that once his patients followed through on the rules then things were “negotiable.” In contrast, Paige, who sees private patients in their homes, discussed her approach to maternity care when she stated, “We are talking about this mom and this baby, not all moms and all babies. One mom and one baby at a time, that’s it.”

It appears there is a significant rift between what women desire, and hope for, when seeking a provider and what is ultimately offered in many cases. There is however, what appears to be an interesting irony when one examines this issue further, an irony worthy of consideration. Women indicated, repeatedly, they wanted to be treated like a person, yet only Eleanor and Lily specifically mentioned questioning the reason and necessity behind a procedure they were asked to comply with that they did not want or like. Some others, like Molly, did question the necessity of certain procedures or protocols post-partum. All made note of various procedures they were told to follow, and several indicated they even knew or believed that the procedure was likely unnecessary, but made no mention of formally questioning (out-loud) or a reluctance to ultimately comply. Emma mentioned the “battery of tests” that are “standard” and stated that she believed many of them were unnecessary, but that she felt having them done was what she “was supposed to do.” Judy also indicated that having the “required tests” was an indicator of being “responsible.” During my conversations with women participants I would often ask why a procedure was done and commonly I heard, “I don’t know,” “I didn’t ask,” or “It’s just what you do, I guess.” This seems to support the notion that the women complied because they felt they had no choice or did not know there was another option.

Additionally, it is interesting that both the women participants and the professionals indicated a belief in the uniqueness of each woman, each pregnancy, and each birth. Phrases like, “not every pregnancy is the same” were common during interviews. Here again is an apparent agreement and understanding between women and providers about unique attributes, yet procedures and protocols remain standardized. So which is it? Are women, their pregnancies, and their births unique or standard?

The underlying concept of this theme largely had to do with the concept of individualized care, both in what women and professionals desired and in the contrasts between what appears to be actually happening. Beyond simply individualized care, it seems that it may be what Wagner (2001) referred to as “humanized birth” (p. 51). Regardless of being a patient assigned a specific pathology, ultimately she is a woman, a mother, and deserves to be treated with human respect. This theme speaks to the way a woman is treated, valued, and honored during her childbirth experience, which seems clearly related with a later theme regarding how a woman also advocates for herself during this time.

Theme 2: Risk and Liability

There was mention of risk (whether briefly or at depth) in every single interview conducted. The professional participants consistently discussed this issue at greater depth than did the women participants. More specifically, the professionals discussed their fear of lawsuits and the means by which they practice medicine to avoid legal action. Women made statements such as being “high risk,” not wanting to “take that risk,” or that a risk was not “worth it.” The frequent mention of this word also seems to support the concept (discussed in more depth in Theme 6), that pregnancies (and childbirth) are perceived to be a pathological and/or risky condition.

Liability and risk are inherently (legally) interwoven, or at least it would appear so; therefore it was no surprise that when participants discussed risks, the idea of legal issues or liability were also frequently noted in their statements. Several women mentioned their understanding that providers needed to “cover” themselves by using “disclaimers,” “waivers,” and “protocols.” – oh my! I understood these expressions to mean efforts that providers engage in to decrease their liability. A common liability measure is the informed consent process (discussed further in Theme 4).

A common example of women’s experiences with risk and liability issues is represented in Molly’s statement:

I felt like risks were overemphasized, I know [doctors] have to do this because they are covering their butts and sadly so much of the medical community is now driven by liability and covering their butts but I just kinda went “alright you have to do this, I get it.”

Paige, who was a travelling registered nurse at the time of her first pregnancy, stated “I was labeled high risk because I wasn’t getting consistent early prenatal care with *them*.” She indicated that she knew where her baby would be born and phoned early on in her pregnancy to explain that she travelled for work, but that she wanted to establish early care with them. She had access to all the appropriate tests and equipment to comply with the “home” hospital’s protocol, but her request to collaborate in this way was denied; she was “just one big liability” to them. She was “labeled a NO DOC,” which meant (according to the hospital chart) that she had no doctor and had therefore received no prenatal care. Following her description of this experience, Paige asked, “What kind of _____ up system are we in?”

Dr. Reid made it clear that he “hates lawyers, on a good day;” he explained that “women see a cesarean as a way out of a difficult pregnancy and lawyers agree. That’s a pretty strong incentive to do cesareans.” Dr. Reid spent more time speaking about risk and liability than any other participant. He was quick to site the risks of a “bad baby” for the doctor and also frequently rattled off risks of pregnancy and various childbirth interventions. He reported that “there’s a real fear of lawsuits” and this fear influences how he practices medicine and makes decisions (see Theme 6). He added, “We have to think legally because the lawyers have made us.” Regarding this type of thinking, which he suggests is rampant in the maternity culture, he stated that it “is not fair to [the woman], but it’s fair for the rest of system.” Dr. Reid also believed, at some level, that this legal presence is perhaps a necessary evil in maternity care as “they (the legal presence) provide checks and balances.” Jessica and Penelope also made note about the influence of the legal system, saying the “lawyers are looking over the OB’s shoulder,” and the impact that has on the experiences a woman is going to encounter during her birth.

The four professionals did seem to agree on one underlying issue and that was, “To change things in the birth world, it has to come from policy.” At one level or another all the professionals, as well as several of the women participants, mentioned the need for systemic and cultural change, typically when risk and liability issue were being discussed.

This theme related to the way both women and professionals indicated an influence on care and practice as a result of risk and liability (legal) issues. Declercq et al. (2007) noted in The Listening to Mothers II technical report that “large portions [of mothers] felt that malpractice pressures led to increased charges and unnecessary tests and cesareans and caused providers to stop offering maternity services” (p. 12). It seems necessary to consider

the impact of such policies (e.g., malpractice related) and [re]evaluate both the potential benefits and pitfalls in the maternity culture. Certainly, there is a growing body of evidence (see Davenport, 2010; Lindgren, 2011; Waters, 2011) to suggest that these issues (risk and liability) are major players in maternity care and with that role comes the responsibility to recognize the inherent power and influence that comes with it – and act according to the best interests of all who have the potential to be impacted.

Theme 3: It Takes a Village

Paige used the African saying “It takes a village to raise a child” to support her understanding that, in her experience, we no longer have a *village* (in concept or reality) in America. The ultimate consequences of this, specifically, of course, to women during their childbirth experiences, were highlighted in our discussion. The notion of a village seems connected to ideas of both support and nurturing and the necessity for these during childbirth and parenting experiences. Several women mentioned that connecting with other positive and encouraging women was supportive and beneficial to them psychologically and spiritually as they approached their birth and parenting. Specifically, Layla spoke about what a difference one woman – who was positive about unmedicated birth, something which Layla was interested in experiencing – made on her personal experience. She said,

I wonder if I hadn’t met her if I would have just gotten the epidural, because that’s what I thought you were supposed to do. Meeting her and hearing her story made me realize it is okay to do it.

Not one participant referred to her childbirth experiences as specifically negative. However, I still asked women what might have enhanced their experiences even more and/or reduced any of their fears. Having positive, supportive, encouragement from others, or specifically from staff, was resoundingly the answer. Judy specifically referred to a desire to

have had a “real conversation” prior to her birth, which seems to indicate a significant deficit – or a lack of genuineness in the conversations that she did experience about childbirth.

Emma discussed feeling a sense of comfort and encouragement from gathering with other women during her pregnancy in what she referred to as, “group therapy with other women.”

Isabella’s comment is a sample from comments by several women who specifically stated that they did benefit from or would have liked to hear phrases like, “It will be okay” and “you can do this.” Layla said, “My nurse telling me I could do it. . . that really made a big difference.”

The role of the labor and delivery nurse should be noted here. Layla, Molly, Lily, Isabella, and Cassandra specifically mentioned the role the nurse played in their births – whether positive or negative. Having a “good nurse” or a nurse who was “positive” and “kind” was noted as helpful in making an unknown and potentially scary experience better for women. Lily’s statement that supports the concept that nurses play an important role in woman’s personal experiences is a good example of the comments I heard. Lily stated,

I had such a good nurse and she was so helpful and encouraging. Then it was shift change and she had to leave. That was hard to have to get used to a new nurse. It really kind of shook things up – it wasn’t fun yah know.

Paige also mentioned “The labor and delivery nurse has no idea how much of an impact she has on each and every single delivery she participates in.”

Women seemed to agree that support – perhaps a village – is something they would appreciate and benefit from during their tenure in the maternity culture and continuing into parenthood. During a conversation about this village concept Isabella simply stated, “Having that kind of support would have been really nice” and Molly mentioned, “That [support] would have made all the difference in the world.” Recall that Declercq (2009) mentioned

that some have cited the United States' "weaker social support system" as one possible explanation for the higher maternal mortality rate.

Issues relating to validation of feelings and experience seem to be fundamentally interwoven in this conversation and context. I spoke with Emma at greater depth about this specific issue – validation. She spoke about how emotionally upsetting it had been for her to feel, as she put it, "dismissed" by other women when she would share her birth experiences. She discussed how she was laughed at and even mocked for having a "too easy" or "not realistic" birth experience. We chatted about how invalidating this felt and how she needed the social space and support to share (and live) her birth experience – whatever it was. She added that she believed women, in her experience, seemed to only want to hear the "horror stories" or the "bad stuff" about birth, and pushed aside anything that did not fall into that realm. I additionally shared with Emma that I had similar personal experiences. I had a baby that was "big" (10 pounds, 6.6 ounces), technically referred to in the medical profession as a "macro baby." When I share (try to) with women that I felt no pain during my labor and that I found birth to be a wonderful beautiful experience I am told that I "have a high pain tolerance" or that "I just do not remember." Instead of having my feelings and experiences validated, by at least being allowed into the social conversation, I am dismissed and excused. I also spent time speaking with Cassandra about similar feelings, specifically for her relating to being unconscious when her son was actually delivered. She has experienced feeling that she has "no story to share." She feels that she is kept out of the social birth conversation – uninvited or dismissed – for her "missing" experience. Paige also spoke about a need to allow women to define for themselves what they feel their experience were and what they meant to them. This appears to mean we have to allow all experiences (and self-

interpretations of them) into the context of the social conversation. We have to create the social space, the forum, to hear and validate all women's lived experiences.

This theme was about issues of support and validation – the need for both and the potential lack of both in the current maternity culture. Wagner (2001) referenced WHO conference proceedings in 1985 which indicated that one goal is that “birth, which had been taken from the community. . . be given back the community” (p. 25). The WHO, among many others, frequently notes the need for supportive community to promote positive birth outcomes for mothers and babies alike. Cahill (2001) wrote that, “The provision of social support throughout pregnancy and labor has been shown to reduce not only maternal anxiety and analgesia consumption but also the risk of prolonged labor” (p. 339). Recognizing and valuing the significance of positive support during birth and the postpartum period is essential to promote optimal outcomes. The current climate of the maternity culture in America appears to be only marginally embracing the significance of this issue. Yet all around us today we read and hear about the connections between the support one receives and the way we then approach that task, no matter what the task. Revolutionizing the maternity culture, particularly in this area of support, have the potential to drastically alter the experiences of American women, their families and their babies – which in turn, impacts all society (Kennell & Klaus, 2005).

Theme 4: Who Is In Charge Here? Power, Control, and Informed Consent

The frequent use of phrases such as, “They said,” “They allowed,” “They did...” in women's accounts of pregnancy and childbirth seems to have possible implications for power and control; therefore, I refer to these as “power phrases.” Issues of responsibility seem to be naturally embedded within these notions of power and control. For example, the person in

the driver's seat (i.e., in control) is typically the one considered to be responsible for the behavior of the car. Certainly there are people who do not like to be in the driver's seat. Likewise some women suggested they do not want to have control or be responsible for the process of birth. Isabella, Cassandra, Judy, and Emma all noted a level of necessity in "trusting" that their "doctor is the expert" and therefore, s/he "should" be the one "in charge" of the experience. This is a stance that many find to be a fitting way to approach the process and culture of childbirth, and it is each woman's choice as to what stance she will take on this issue. However, the question that I have is, "Why?" The answer typically seems to connect to the perception that birth, by default, is inherently risky or pathological and by having someone else – a trained expert – in the driver's seat, one is more likely to achieve a safe and positive outcome.. This philosophy and approach is apparent in women's statements such as Layla's statement, "I don't know what I'm doing, [the doctor is] the expert." In contrast Dr. Reid stated, "I'm not in charge of the wave, I just ride the wave" – the wave he is referring to was interpreted as both pregnancy and birth. Again, I simply question why some or many women think and feel that they "don't know." The ultimate question I ask here is, "do women actually have the choice to be in the driver's seat or not?" In order for a woman to be able to hand over the keys and choose the passenger seat option, she had to have had the keys in the first place. Which experience (driver or passenger) makes the woman feel good, feel empowered? Ultimately only she can decide this, only she can say what that may be, but she can only do so if that choice is truly available to her.

These "power phrases" and the implications for control and choice issues seem to be intrinsically linked to the concept of informed consent. It was rare in this research to find a woman using expressions like, "They asked me," "They offered me," or "we talked about"

and then follow those phases with a description of a conversation that would indicate informed consent had occurred. Rather it was statements such as “They gave,” “They went in,” “They had to” that dominated the telling of their birth stories. Some women stated specifically that they were “not asked” (about consenting to a procedure or intervention); instead they were “told what was about to happen” to them and “what to do” and they “did it” – there was no choice given regarding the matter or a formal consent process engaged in. However, as Paige said, “not consenting is, *not* consenting,” meaning lack of consent (or refusal) must not be mistaken for actual consent.

Paige offered this challenge during our conversation about consent and choices:

Think about it -- do we, not just in birth, any of us, question our health care providers? Like, really question them. Do we ask them the reasons and motive behind a recommendation they're giving? Have you ever done this? How did it feel? Did you like how it felt? Were you comfortable about it? When a doctor gives his or her recommendation, their *expert* opinion, what further questions do you have for the doctor? Do you ask about alternatives, about risks of following the recommendation versus not following it?

This theme addressed both systemic and historical hierarchies and their impact on modern day birth definitely were addressed by the participants. Declercq et al. (2007) stated that “By law and through ethics statements of the leading professional organizations, women are entitled to full informed consent or informed refusal before experiencing any test or treatment” (p. 13). The Listening to Mothers II survey (Declercq et al, 2007) asked women about this issue (informed consent/refusal) and found that “Most mothers stated that they had fully understood” their right to refuse a treatment or procedure. Mothers were then asked if they had declined any “forms of care” while in the hospital.

Despite the very broad array of interventions presented and experienced, widespread belief in the value of avoiding unnecessary interference, and a high degree of understanding about the right to informed refusal, just a small portion (10%) had

refused anything. Of concern, the great majority of mothers who had experienced episiotomy (73%) stated they had not had a choice in the decision.” Additionally, mothers were asked about their knowledge regarding potential side effect of various interventions (e.g., induction of labor, epidural, cesarean). (Declercq et al, 2007, p. 13)

The Listening to Mothers II report also indicated that “whether mothers had the specific intervention or not, they were poorly informed about a series of complications of labor induction and cesarean section: most had an incorrect understanding or were not sure.” (p. 13). What this report demonstrates so well, which also appears evident in my current research, is a significant gap in what women believe [or want to believe] they know and what they really know. Additionally, this may lead one to question who then is responsible for ensuring mothers have accurate and appropriate knowledge on which they base their decisions. Legally, the answer is the providers. This leads me to question why this is not happening, and furthermore, to what/whose benefit is this (accurate and appropriate dissemination of information) not occurring? Wagner (2001) suggests that

. . . there are, in principle, two approaches to assisting at birth: work with the woman to facilitate her autonomic responses – humanized birth; override biology and superimpose external control using interventions such as drugs and surgical procedures – medicalized birth. . . . Whether the care is medicalized or truly humanized depends on whether or not the woman giving birth is in absolute control. (p. 26)

Theme 5: Asking Questions and Self-Advocating

Discussion about power and control seems to lend itself easily to questions about a woman’s role in [re]gaining and owning her own power in the given situation. During my conversations with participants I would often ask why a particular procedure was recommended and/or performed. Cassandra offered an example of an all too common response, “I’m not sure actually; I didn’t ask.” Layla stated, “I just assumed it was

necessary.” Layla introduces a notion that seems interwoven with the previous theme (4) regarding the assumptions consumers of maternity care make about knowledge and power. I confess that such responses were also similar to those I heard during my mini-thesis research and some of what encouraged me to continue with this topic of inquiry. It seems appropriate to question why women seem to be less than informed about their care and moreover to ask why is it that women are not asking questions about the care they are receiving or recommendations that are being given. Simply put, are women asking questions of their providers? Are women aware of their options and if not are they advocating for themselves to ensure they know them? Are women informed about their patient rights, including the right to ask questions about their care or to refuse any treatment?

“By any means necessary to [get the baby out], so let’s not ask questions about the rest of the process,” was Judy’s statement regarding the matter of questions and consent. Her statement reiterates the belief that we (Americans) should not question medical care providers. What was highlighted in the critical thinking challenge (Paige offered) was the notion that, in Paige’s experiences, it is likely that few people (in contexts outside of childbirth) give informed consent. American society, our culture, has taught us to behave in a certain, submissive manner when interacting with medical professionals. This social construction, as it is known, is based on the inherent power-dynamics – the person with the knowledge (the expert) holds the power. Therefore, it seems fitting to reflect on the woman’s feelings about this. How can she be empowered, if, the maternity culture defaults her to not be in the power position? If pregnancy and birth are defined as pathological or pathogenic (see chapter 2, the historical review), then the woman *needs* both an expert and a cure. By

this cultural philosophy (pregnancy and birth as pathological) a woman is defaulted to a dependent position.

This also seems to relate to the concept of “the good patient” and what women have experienced and/or fear if they question their care provider(s). Several women indicated they were consciously aware of their behavior during birth and intentionally suppressed their impulses,³⁵ to comply with the image of a good patient. Layla stated, “I was really aware of how loud I was being and I tried to be quiet, yah know, I don’t want to be drawing attention or seem crazy.” Women also indicated an awareness, or fear, of being labeled in a negative manner by the medical care providers if they “complained” (questioned) instead of complied. Both Isabella and Layla spoke about how they felt their questions or comments were “annoying” for the providers. Lily also mentioned that she felt her admitting nurse was “frustrated” with her when she “refused to sign the consent for epidural.” Lily went on to explain that she felt this nurse was hostile and even rude to her. According to participant accounts, it appears the good patient is quiet during labor and birth, quick to comply, and places her trust unquestionably in her provider.

I have continued to struggle with the separation and overlapping between this theme and the previous theme (who is in charge here?) – as they seem intrinsically interrelated, yet also distinct to me. Therefore, with this in mind I will address women’s role in the inherent power-dynamics of childbirth.

In a 2006 roundtable discussion article in *Birth* titled “Why do women go along with this stuff?” Simkin contributed the following response:

³⁵ Synonym: naturalness

Why do women go along with this stuff? Implies that women have choices and are making poor ones. It is not quite that simple. The fact is that many women have few choices, but even when they do, they tend to not question their care. They want to believe “doctor knows best” because they need, during this vulnerable time, to trust their care providers. (p. 247)

Simkin (2006) pointed out several things in her response, two of which I believe are worthy of highlighting. First is the notion that a woman is “vulnerable” during labor and birth. Few would argue that her body, during labor, is quite literally taking over all functions for the sole purpose of delivering the baby. In many ways, she truly does have no control over this biologically mandated process – her body (and the baby) are in control. This is a naturally vulnerable state of being. Simkin adds that as a result the woman “needs” to be able to trust. I suggest, based on this notion presented by Simkin, that psychologically a very serious contrast arises when one feels vulnerable and unsafe (not trusting). If a woman finds herself in this type of emotional conundrum, fear is sure to follow which lends itself to other psychological and physical impacts on her birth experience.

During my mini-thesis research (Hardy, 2010) decision-making power was one of the themes found in the data. It appears that this notion again applies to the findings of this present study. Waldenstrom (1999) indicated that “perceived control” and “support” during birth were both associated with reports of positive birth experiences. Waldenstrom’s (2004) study also indicated that support may have long-term effects, specifically as a protective factor against reporting long-lasting negative experiences. “Anxiety,” “pain,” and “fear” were associated with reports of negative birth experiences. Wiegers, Van Der Zee, Kerssens and Keirs (1998) studied home birth choice in the Netherlands, a country in which most births do occur in the home, and reported both fear and social factors influenced how women in this country made decisions about where to give birth. It seems worthy to explore this

particular area with future research which asks specific questions about power, control, decision-making, and self-advocacy.

Theme 6: Fear

A statement like Isabella's, "He's the doctor-- he knows, so I guess I have no choice. Then I was scared," weaves together the concepts from the two previous themes with the notion of fear. Feeling a lack of choice or lack of control was often cited as influencing and increasing fear. Molly said, "Not getting to be a part of that decision or understand it really was very difficult and scary." Cassandra also shared that "not feeling in control was really overwhelming and scared me a lot." This certainly makes sense considering that choice and control both are psychological constructs. Many women remarked that pregnancy itself brings with it a feeling of one's own body not being their own anymore. Scholars have often used the word "vulnerable" to describe a woman's physical and psychological state during pregnancy and childbirth – and I would add to those periods the time of early parenting. Therefore, making a connection between power and control issues and fear is not a great leap to make.

Every interview with the women participants confirmed that fear, at various levels and contexts, was present during their pregnancies and births. Simply put, if participants had not spontaneously mentioned elements of fear during our conversation, I had interview question prompts prepared to ask about this. When I would ask, "What were your experiences with fear?" only one, Lily, did not immediately respond that she experienced fear and most changed their voice tones to add emphasis to their response. Lily indicated that fear was not the right word, but that she felt "anxious" at times. Different sources or types of fears were reported, from being in the hospital, like Isabella and Eleanor, to pushing

the baby out, like Judy, to not knowing what was happening, like Emma, Molly, and Cassandra. The professional participants also all noted their own fears and also confirmed by their own observations that women experience fear and anxiety during their pregnancies and births. Dr. Reid said, “A big goal of my job is to reduce fear” and that he is “amazed at how much fear drives every aspect of what I do.” Professionals indicated that their fear was primarily of lawsuits and that this fear significantly influenced how they carry out job duties and interact with women consumers (i.e., patients).

Both Isabella and Eleanor specifically indicated that they did not like being in the hospital, but others, like Emma and Layla also noted that “being a patient” brought a certain level of discomfort. Being in the hospital or clinic setting increased their stress levels and anxiety. Layla mentioned a desire to discharge as soon as possible, “I wanted to be at home” where she felt more “comfortable.” Emma stated that when she got home from the hospital after the birth of her daughter she, “just bawled...there must have just been this weight that I was carrying, and once in the confines of my own house I could let it out.” This final statement struck me as particularly poignant and again potentially representative of the idea of the “good patient” – a woman in *control* of her emotions, or at the least not expressing them publically. Additionally, Emma’s statement speaks to the idea of emotional safety and security. She implied that her home was a space (her turf, if you will) where she felt safe enough to express her emotions. This notion suggests that hospitals, perhaps by default, are less equipped to provide this emotional security. In fact, Penelope indicated that she believes the hospital is a “system set up to treat superficial things.” She went on to describe how nurses are trained to ask women to rate their pain, but not to ask them how they are *feeling*

and what they can do for them personally to make their experience as pleasant and comfortable as possible.

Despite the fact that many women mentioned home as feeling better or more comfortable and a place of emotional safety, it was the hospital that the women chose for their physical safety and the safety of the baby. However, Eleanor, who also indicated that the hospital made her nervous, said “It made more sense” for her to have her baby at home. Eleanor said, “At home I know the space, I guess, and that makes me feel comfortable and safe, so then I am able to relax and not stress as much as if I was around all the stuff in the hospital.” Eleanor believed that her emotional state of being influenced her physical state during childbirth. Penelope, Paige, and Jessica also mentioned the influence of the “mind” on “[labor] progress” and “experiences” during birth. Specifically, Penelope said,

Some people can’t labor because they are so anxious about it, they never get in a labor pattern, they can’t get them into a labor pattern, even with pitocin or anything else...the mind certainly has something to do with it.

Emma, Lily, Layla, Molly, and Isabella also mentioned “stress” and/or a need to “relax” during both their pregnancies and births. These women also noted a connection between their psychological relaxation and the progression of their labors. Emma said, “When I finally did [relax] my body was able to labor and progress...instantly.”

This theme addressed the way in which fear influenced both women and professionals experiences with childbirth, and specifically explored some of the potential sources of fear in the maternity culture. I went into the present research with specific questions about fear, which I had developed following my mini-thesis research (Hardy, 2010). It seems apparent to me that fear is a strong underlying issue when it comes to birth experiences and outcomes. Paige (CNM) also indicated there is some fear that seems to come naturally with birth;

however what she sees now is an “unnatural kind of fear.” Of course, in birth, like in many things in life, there is inherent uncertainty and with that comes some *natural* sense of fear and concern for the outcomes. However, as can be seen in my historical review in chapter 2, it appears that when birth began to fall under the “medical gaze” (Foucault, 1973) that this natural type of fear started to shift.

Exploring and addressing these underlying fear issues may lend to further understanding and potentially influence social changes in childbirth. Kass (2002) indicated that “instrumental births were certain to be extremely painful” (p. 156). Around the mid eighteenth century as instrumental deliveries were increasing, historians have indicated that there was a shift in the social perceptions about pain in childbirth as well (Cahill, 2001; Rothman, 1986b; Wertz & Wertz, 1989). The most commonly cited fear among participants in my research was fear of pain; I feel this is certainly significant.

Theme 7: The Power of Perception

Perception is a very powerful psychological construct. What this concept presents us with is the notion that if we perceive something and then believe it to be real, then (for the believer) is it ultimately real. If I perceive that I am in danger, my body reacts (physiologically) as though I truly am in danger. My heart will begin to race, my breathing may shorten, I’ll begin to be hyper-alert and hyper-sensitive, I will struggle to concentrate, and so on. Whether the danger (the source of fear) was real or *just* my perception (in my mind *only*), physiologically it does not matter – it is real because I believe it to be, and my physical body responds the same. For example when someone accidentally startles you, the threat is not real, but your body still responds as though it were real. The startle (stimulus) sends your mind into an automatic response mode – commonly known as fight or flight.

One indication of women's perceptions regarding pregnancy and childbirth was noted in the way they discussed their health (discussed in theme 8). Nearly every woman participant stated that her pregnancy was "uneventful," seeming to imply that, for whatever reason, women assume that some "event" (appearing to be medical) was anticipated as likely to occur. Layla said, "My pregnancy was pretty uneventful, so I guess I'm really lucky in that way." Common first descriptor phrases like this seem to imply that women are defining (perceiving) their pregnancies and births in medicalized terms. No women in this project simply stated her pregnancy was "good" or "exciting" or "a beautiful time" as a first descriptor; instead it was uneventful. This is not to imply that one potential descriptive expression is more desirable or dare-I-say better than another, but simply to provide an alternative or contrasting descriptive option, which could have been used. Lily said, "My pregnancy was uneventful, but I did get . . . a pregnancy rash." Cassandra stated, "My pregnancy was pretty uneventful; I did have some high blood pressure at the end." This use of language certainly has implications worthy to reflect on in this conversation about perceptions when one considers the information presented in the historical review (Chapter 2) and the influence of social construction on modern day birth experiences.

Another consistently reported perception was that women believed childbirth was going to be painful and this caused fear. Judy said, "It's going to hurt. Gonna hurt, hurt, hurt." Isabella stated that she, "really believed that it was going to hurt and be bad." In contrast, many would also mention a belief in their body's "natural" ability to give birth, because after all, "Women have been doing it since the beginning of time," as Judy stated. What was interesting about the perception about pain was that some cited their own shortcomings or emotional/physical weaknesses (inability to endure the inevitable pain) as a

reason for not being able to “trust” the “natural process.” Emma said, “I’m kind of a wimp;” Cassandra said, “I have a really low pain tolerance.” Both Emma and Judy compared the anticipated pain of childbirth to that of having had a broken bone. What I am trying to highlight here is the influence of language on perception. In truth, language could be considered even more powerful than perception itself, for language has a significant ability to influence our realities. In a final irony regarding this matter of language and perception, Emma, Isabella, and Layla all reported that in the end they found childbirth to be “not that bad.”

In response to inquiries about their experiences and perceptions of fear and its influence on their births, I followed up with a question about where they believe their fears “might have stemmed from” or the *source* of their fears. Undeniably their quick and prominent response was TV and movies or simply “media.” Judy said, “You see all this stuff on TV about how much it hurts and how bad it’s going to be and the screaming and all that.” I would not be the first to note the significant influence the media has on American culture – it socializes and shapes; it constructs. Emma spoke at length about the way her own mother spent a significant amount of time during her pregnancy trying to “convince” her that what she sees on TV and in the movies is “dramatic” and not accurate. Emma’s mother told her, “Don’t believe all the drama you see on TV, it’s not real.” Ultimately Emma shared that she found the messages from the media to be so powerful that she struggled to believe her mother; she said, “I know she’s my mom, but the stuff you see on TV just plants that seed in your head, and it’s hard, yah know, it’s powerful.” During our interview we shared a laugh – in hindsight – at the notion that she believed the TV over her own mother. This is a poignant

example of the power of perception and implications of the messages the media send to women and the way women are internalizing these messages.

In addition to mentioning the role of the media, several went on to mention – in response to this specific line of inquiry or in other contexts of our conversations – the “horror” or “war” stories they have heard from other woman. Another common response to questions about sources of fear and childbirth perceptions were descriptions of social influences and what others “say” and “tell” about birth – again, emphasizing the influence of language on perception. Several used the word “crazy” to describe having an unmedicated birth or giving birth at home. The women who did mention a desire to have an unmedicated birth indicated that they either heard from others or felt that others believed them to be crazy for this desire and in fact found themselves often discouraged (verbally), even by strangers, to not have an unmediated birth. Layla spoke about how many women – women she hardly knew and women who had never given birth – asked her “Why go through all that [pain] if you can get the epidural?” Eleanor, who had two planned homebirths, indicated that she also was called “crazy” for her choice to birth at home. Additionally, she stated that others often called her “brave” to birth at home, seeming to imply that she was taking a risk in doing so. Such statements about Eleanor’s brave or risk-taking behavior simply speaks to the power of perception and the social climate surrounding birth. As has been previously indicated (see Chapter 2) in this study, the reality is that Eleanor is taking no more risk than any woman in labor. Despite this reality – that birth is safe and therefore, safe at home – the perception is obviously quite to the contrary.

Overwhelmingly women reported that the social climate surrounding the concept of unmedicated birth and/or homebirth – or perhaps anything indicating a less medically-

managed birth -- was, simply put, crazy! Judy made note of this social climate by stating, “The complete opposite of natural is regular, and natural is an alternative and really hippie-dippie. They look at you like you’re crazy.” In addition to mentioning craziness, there were other indications from the women that they felt judged – socially – for the method of delivery or other birth experiences. Judy also commented that she had heard that, “C-sections are for celebrities who were too vain to have babies. That’s what people think about women having c-sections.” Somehow, at the very least this seems to seek to a potential, or apparent, distortion of reality, which is both worthy to note and address in the context of this discussion. What this distortion may be contributing to is the further marginalizing and silencing of women, it has the potential to feel quite dismissing and perhaps diminishing.

This theme was originally called “what the TV told women” to highlight the apparent impact of how influential media seems to have been in impacting women’s perceptions about childbirth. Employing a constructivist worldview for this research lends itself to recognizing the significance of perception and the way society shapes (constructs) these perceptions. When I went about researching the history of childbirth, specifically the history of childbirth in the U.S., it was then that I came to better understand how pervasive and profound the medicalization of childbirth has been. If one were to turn back the clocks and change the way childbirth was [re]defined around the mid eighteenth century, our experiences in birth today would no doubt be extremely different. In the introductory chapters of this research I presented a more thorough argument regarding the true causes that spurred the significant changes in childbirth and offered some claims to potentially debunk some commonly held myths about birth. Cahill (2001) wrote:

[There are dominant] assumptions that underlie much of the current medical practice and that may compromise and disempower women in other ways during their experience of pregnancy and labor. So despite placement of the pregnant woman at the center of the maternity care...there seems to be a point at which the value of the fetal life begins to outweigh, perhaps not so much the life of the mother, but perhaps her right to self-determination, her plans and her choices. Medicine's construction of pregnancy as pathological seems so entrenched that an increasing gap between lay and professional birth cultures seems inevitable. (p. 340)

What I aim to point out here is that simply put, if birth had never been defined as pathological and an event that could be "cured" through technology, how might women describe their modern experiences – more specifically how the experiences relate to the theme of health reports. The pervasive belief that both women and their unborn babies are in peril opens the door to excuse any oppressive acts carried out against her. Such a belief, that pregnancy and childbirth are pathogenic, suggests that the potential oppressors are instead heroic in their actions.

Certainly, I do not argue that no pregnancy and birth is without pathology -- absolutely not. Like all things in life, there is deviance from the norm which does occur and sadly, in birth and in life, sometimes this deviance is tragic. I do not intend to minimize in any way the deeply personal significance of any such tragedy ever occurring, but simply to acknowledge that I am not attempting to claim or argue that this (tragedy) is not a reality, albeit a difficult one. However, what I aim to address here again is the notion, and impact, of the assumption of a pathological condition.

Consider the following question: In how many situations in life, in which 85-90% of all cases are considered normal, would those cases be perceived and treated as pathological, risky, and dangerous? Some people would argue that even a 10% risk in birth is too high a risk and I do not disagree with this. These are the cases in which the advancement in both

science and medicine has the power to be extremely beneficial and life-saving. However, it is again necessary to recognize that the 10-15% of cases, which do deviate from the norm, are still not conditions which necessarily put either the mother or the baby in peril (i.e., a life-threatening situations for either). A baby in a breech or posterior positions, twins, and deliveries at 38 weeks or 42 weeks are all deviations from the norm, but are not necessarily life-threatening. Even the obstetrician I interviewed for this project, Dr. Reid, noted that it is only about 1% of cases that truly “come out of left field” and are potential “disasters.” Even Dr. Reid stated that he thinks these are the cases that often no one can predict (i.e., potentially prevent) and are simply “real emergencies.” What seems to have occurred in birth in the U.S. is that all births are now treated as if they might be that 1%.

Declercq (2009) referred to this phenomenon as the 1% doctrine, a concept based on former Vice President Dick Cheney’s widely cited comments about terrorism. Pulitzer prize winning journalist Ron Suskind (2006) wrote a book titled *The One Percent Doctrine* based on Cheney’s comment. The reported comment was that, “If there is even a 1% chance that [something/someone is involved in terrorist behavior] we must treat it as certainty.” Naturally, there is solid argument as to why this should be the case and I will not argue that most would want to do whatever it takes to avoid being in that 1%. However, in the process of attempting to avoid being in this 1%, women have, perhaps willingly, been silenced, oppressed, and disenfranchised and have come to believe that the silencing and disenfranchisement is in fact in their best interest. What I am attempting to point out here is simply the powerful way in which perceptions (whether accurate or not) construct our reality (Aristotle, cited in Knuuttila, 2008; Lee, 2011).

Theme 8: Health Reports

I started all of my conversations with women by asking them to “Tell me your birth story” or some variation thereof. All the women began their birth stories by indicating a measure of health. Most would use the exact phrases, “healthy” or “uneventful” to describe their pregnancies. Their stories about their pregnancy and childbirth experiences were always preceded by health statements. This seems an appropriate representation of the way the medicalization of childbirth influences individual perceptions of the experiences. Dr. Reid stated, “What is making women focus on pathology? The medicalization of a normal process.” He went on to indicate, “[providers] don’t talk about or remember what went right, we talk about what went wrong. That’s the language medicalization brought. The women hear it and talk to their friends using it and so it goes...” In fact, I often had to prompt and probe for women to describe and share emotional experiences, but never for physical or health experiences. The birth stories I heard were quite often a telling of health, medicine, and management, of procedure and protocol, but rarely focused on personal transformation and metamorphosis to motherhood. Ultimately, it seems appropriate to suggest that if the medical view potentially has influenced American women’s way of telling about their childbirth experiences, how too has it impacted the way in which they understand and internalize those same experiences?

Parallel to the way women reported their own health outcomes, there was a clear focus on the health of the baby. In fact, statements from some women seemed to imply women approached childbirth with the notion that their child was in danger. Statements like Cassandra’s, which were echoed by all the women in this study, “The baby was healthy, so it was all okay” seems to support the notion that there is an assumption that the baby being not

healthy was a feasible, perhaps expected, outcome of pregnancy and birth. Of course all agreed that the outcome of a healthy baby is more than simply a desirable outcome – and I do not mean to imply anything less than this. However, I simply offer this here as another possible representation of the influence of history and the social construction (medicalization) on our perceptions.

What I intend to suggest here is that it might be beneficial to consider one's definition of health. Simply being alive – having breath and a heart-beat – is not the entire scope of health. Paige argued that it should be up to “each and every person to be empowered enough to define [health] for themselves” rather than have it defined for them – by society, by medical professionals, and so on. The notion I aim to present is that of a holistic picture for both mother and baby. When this broader (holistic picture) of health is taken into consideration, the entire experience and image of childbirth practices can be reframed and with this reframing comes a potential change in perception.

“At any cost, get baby out healthy,” was Judy's comment about her expectations for childbirth. It would appear that due to the perception (baby is in danger), more women are willing, perhaps prepared, to subject themselves to potentially unnecessary treatments (emotionally and physically) in order to ensure the outcome of a healthy baby. When one considers that this narrow focus on health – the social climate surrounding birth in America – may in fact be based on little evidence, that perhaps one is then able to consider that things could be different.

Hearing just one woman refer to something “they” (e.g., medical providers) did to her or her baby during birth was one too many – and sadly I have heard far more than just one make such statements. It was not simply women making these statements, which to me are

examples of potential disenfranchisement, which struck me, it was the fact that the women seemed to be excusing the actions as “fine.” Countless times in actual research interviews and in my personal experiences in life, I have heard women share with me their birth story. Far too often women would share a disenfranchising experience (i.e., something done to her), which was promptly followed by a statement like, “But my baby is healthy and I am healthy, so it is all okay” or “so that doesn’t matter.” Of course I do not, nor would I ever, disagree with the value of health of both mom and baby; however, does that health excuse the treatment she received? Cahill (2001) wrote about the “price” a woman pays for the “assumption that hospital means experts and that surely means a safer birth” (p. 340).

These “but” statements about health appear to be overemphasized and valued in the present maternity culture. They also may be representative of ways in which the hegemony of the maternity culture is maintained or re-inscribed within the culture. Again I am adopting Madison’s (2005) definition of hegemony to mean “The way in which dominant classes control and exploit subordinate groups by consent, thereby masking exploitation by convincing the exploited that their condition was natural to them, even good for them” (p. 53). With this notion that Madison provides, the way some women indicate and dismiss their experiences (regardless of those experiences) as “fine” or “okay” based solely on medical definitions and measures of health might be indicative of the hegemonic structure. Davis-Floyd (1987) reminds us that “in over-emphasizing the physiological (i.e., safety) aspects of pregnancy, it both underestimates and undervalues vital psychosocial changes occurring within the woman as she undergoes this important transition in her social status (i.e., from woman to mother)” (p. 494). In addition, it undervalues some important aspects of pregnancy and birth that can impact the newborn (i.e., hormones send cues of readiness for

birth) not only prenatally but at the actual time of birth and afterward as well (see earlier discussions about attachment, breast feeding and bonding in Chapter 2).

Not only did the women's statements seem to indicate the overemphasis on health, Dr. Reid also reinforced the apparent or assumed value of health regardless of experience and feelings when he stated, "Why are [women] feeling defeated? If you had a healthy baby and a healthy mom you won." Such a statement is marginalizing and silencing. If a woman, for any reason, is feeling defeated she has a right to feel this way regardless of the how or why. It's *her* birth experience – it's hers to define. This focus on the medical definition of health is most certainly a worthy example for reflecting on; perhaps with this definition, women are being convinced that their condition(s) or experience(s) (whatever they may be) are in fact, good for them and their babies.³⁶ This notion that actions carried out by providers during childbirth are in the best interest of maternal and fetal outcomes and that their outcomes were likely to have been pathological, or "disasters" as Dr. Reid called them, without the intervening actions of providers, has historically become socially accepted. Such a notion is now so entrenched within the American model of birth that few women likely even question that exploitation, silencing, or oppression may have anything to do with making a "but" or "okay" statement.

Recently, I was chatting with several women and the topic of childbirth came up. One woman shared her birth story in the context of the conversation. She spoke, like so many others I have heard, about an experience which she did not enjoy. She spoke about experiencing a lot of fear and stress during her birth. She, like so many others, quickly ended

³⁶ Recall Madison's (2005) definition of hegemony: "...masking exploitation by convincing the exploited that their condition was natural to them, even good for them" (p. 53).

her story by adding, “But my baby was healthy so that’s all that matters.” I looked at her and said, “you are right, you baby is healthy and that is wonderful, but how you feel matters too. You matter.” She smiled and agreed. It was one small way that I felt I could validate both her healthy baby and her personal feelings about her experience – whatever those feelings may be.

The Baby: Un-finding

“The baby,” was my “un-finding,” which I presented to my external reviewers to seek their feedback as I considered developing it into a final theme or “actual” finding for this project. This un-finding was created based on its lack of representation in the data. It struck me as interesting that other than “the baby was healthy” statements (discussed in more detail in the health reports theme above), there was little mention of the life-changing impact a birth has on babies – in the sense of well-being. Naturally, a baby cannot report the way in which they experience their birth, but this inability makes them no less an active participant in the birth experience and as such has the potential to be influenced (in life-long ways) by that experience. Only three of my 12 participants made comments about the baby’s experience, feelings, or role during birth. I provided the following statements (direct quotes) made by participants to reviewers for the sake of further personal reflection on specifically how this lack of finding relates to the social construction of birth in America. Paige stated while discussing the implications of planned elective cesareans that, “Nobody ever told the baby that anything was going to happen...there was no post-it-note stuck to the womb saying today is the day.” Paige also added that “There is a powerful voice that babies have, that we as a society have learned to ignore.” When discussing the way in which the birth experience, specifically the impact of hormones have on breastfeeding. Jessica also discussed hormones

and breastfeeding similarly when she said, “We’ve got to have an open dialogue...breastfeeding, hormones, the baby. . . .” she added concern about the “Separation of babies and moms following birth.” Layla mentioned, when discussing going into spontaneous labor, “It prepares the baby.” Finally, on this issue, it was Paige who said, “The baby had a say in it, it’s not all about me, it’s about our journey together.”

Regarding the issue of impact of birth on the baby, Declercq et al. (2007) stated that “A vast body of evidence is accumulating about lifelong implications for babies of the medical, physical, and social environment during this crucial period” (p. 14). Additionally, a 1985 WHO report, indicated that

. . . by medicalizing birth, i.e., separating a woman from her own environment and surrounding her with strange people using strange machines to do strange things to her in an effort to assist her, the woman’s state of mind and body is so altered that her way of carrying through this intimate act must also be altered and the state of the baby born must equally be altered. (p. 25)

In chapter 2 I presented a section (beginning on page 17) regarding the potential impact which birth may have on the baby. Although, at this point in time, we are unable to truly *know* what this impact might be, it still seems valuable to consider. Regardless of our understanding there is an impact nonetheless on the baby. As such the baby’s experiences should be acknowledged and valued. Assume for a moment that babies, in some manner or another, do in fact maintain some type of memory of birth (e.g., imprinting). Birth is our first experience with the world. During these first moments we have the potential to begin forming our initial concepts of what kind of a place the world is and about the people in the world. Is the world a friendly place, a welcoming one, is it scary, traumatic, or chaotic? Are the people loving and kind, trustworthy, and respectful?

Although I did not opt to develop my un-finding into a final theme for this project it is still worthy to present, as ultimately an un-finding is still somewhat of a finding. My hope is that others, as well as myself, will continue to reflect on and be challenged by this un-finding. Why did the majority of women in this study not discuss the baby in a manner other than to report health outcomes? How is this important when we consider and reconsider the American birth story?

Summary of Part II

In the previous sections I presented the findings from this study and attempted to integrate these findings with both the literature and my own understandings of their potential meaning and implications. In addition to the way in which I presenting my findings above in order to synthesize, integrate, and consolidate my understanding and specifically return to my research questions I have provided the following matrix (Figure 4). I have provided my original research questions and then indicated which themes I feel best address or offer the best insight into a possible answer for that question.

Figure 4: Matrix Reflecting Original Research Questions with Corresponding Themes

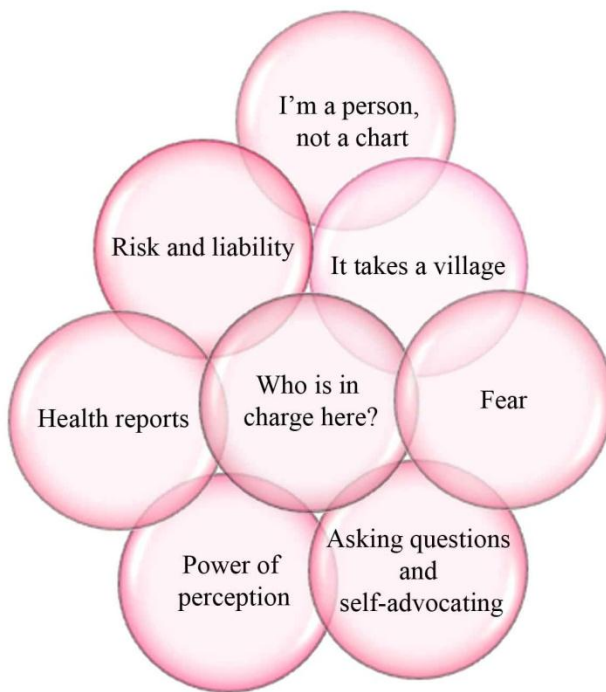
Research Question	Theme
What are the childbirth experiences of American women, specifically those which relate to disenfranchisement?	Theme 1: I'm a person, not a chart; Theme 3: It takes a village; Theme 5: Asking questions and self-advocating
How do women make meaning of their childbirth experiences?	Theme 8: Health reports; Theme 4: Who is in charge here?; Theme 5: Asking questions and self-advocating
How do women navigate and interpret the maternity care culture in the United States?	Theme 6: Fear; Theme 7: Power of perception; Theme 3: It takes a village
What roles do socio-political and historical contexts play in individual experiences?	Theme 2: Risk and liability; Theme 3: It takes a village; Theme 6: Fear; Theme 7: Power of perception

Finally, it is abundantly evident to me that each of these themes is interrelated, influential, and/or interacting with one another. In some regards this made it sometimes difficult to sort out and know where a quote or concept presented by a participant “belonged.” As a means to attempt to summarize my understanding of these themes, and my experiences with this research, I have created a graphic representation (see Figure 5) as one way to demonstrate how I believe the themes are connected to one another. I refer to this graphic as a “cluster,” as there is no particular directionality or hierarchical structure, per say, but simply as a means to visually represent the way I believe the themes may be “touching.” I was asked by a colleague to describe how I determined where each “bubble” would be placed in this graphic representation, I stated that I could see the themes in my head and I can hear my participants’ voices within each. They float around somewhat like bubbles and often bump into each other, bounce off each other, or even at times seem to join together with one another. Ultimately, I described the placement of the themes in the cluster as being represented this way because I felt they were “touching in the text,” meaning I have clustered them this way with intention based on the voices (which became text) of participants. This does not mean my graphic representation, this cluster, is stable, but rather that I see it as a fluid object or system subject to change. Organizing the themes in this manner helped me represent, and also understand, how certain themes were connected or “overlapped” with another, whereas other themes perhaps had less connection with another. For example, Theme 3 – It takes a village seemed to have less overlap and influence on or from Theme 8 – Health reports. However, Theme 4 – Who’s in charge here: Power, control, and informed consent (labeled only as “who is in charge here?” in the graphic) appeared to be related to various other themes like Fear (Theme 6), It takes a village (Theme 3), I’m a person, not a

chart (Theme 1), and Risk and liability (Theme 2). I feel this cluster graphic represents the themes as relational but not hierarchical or causal in their relationship with one another.

Although one could argue that such relationship may very well exist and could potentially be represented, I felt that for the purposes of this research project such claims and representations were not necessary to understand the interactions nor do I have evidence of hierarchy or causation per se.

Figure 5: Graphic Representation of Themes



Results from Cohort Group

One of my proposed research questions asked about how childbirth experiences have changed in the past 40 years (between the 1970s and 2000s). During this 40-year period a mother and her daughter both potentially could have given birth. It was simply interesting to

explore in this area and what changes one might notice between one mother and one daughter giving birth during this period.

I indicated in chapter 3 that I reflected on the nature of the question I was asking and determined that ultimately the type of question, attempting to measure change, was not best suited to be addressed with the qualitative measures which were used in this study. This does not reduce my interest in the question or the fact that the question itself is interesting, and that answers should be sought, but simply that my research methods were not the best way to go about seeking an answer. Therefore, I have chosen to present the data from my interviews with two women from each decade (1970s, 1980s, and 1990s) here for you, the reader, to reflect on as you wish. The same “data” (key words and phrases) also were collected from the women group; however, since their stories and experiences are shared in greater depth and include more participants (chapter 4, part I) I have not shared that data in this section. Certainly these results, their words represented graphically using wordle.net, are interesting and potentially speak to some “answers” to my question about changes; however, I do not believe they are enough to make any such claims.

Figure 6: 1970s Cohort Responses to the Question “Describe your experience with childbirth in three words or phrases.”

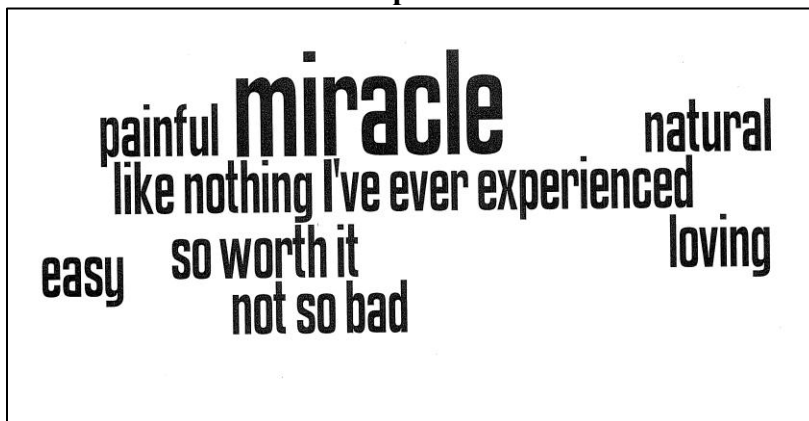


Figure 7: 1980s Cohort Responses to the Question “Describe your experience with childbirth in three words or phrases.”

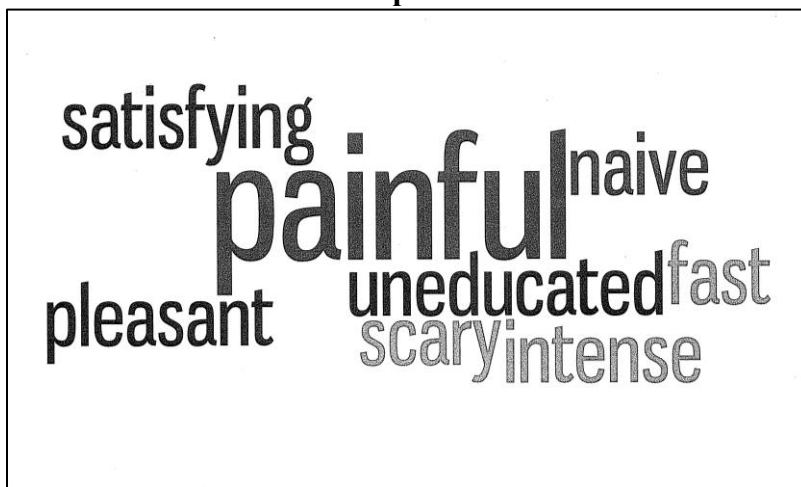


Figure 8: 1990s Cohort Responses to the Question “Describe your experience with childbirth in three words or phrases.”



CHAPTER 5

DISCUSSION AND IMPLICATIONS

It's dark. It's the middle of the night. A woman lays immobilized in a bed in the middle of the room. She is frightened. She does not know what is happening to her or what is about to happen. A man enters the room. He is followed by a woman accomplice; she also says nothing but does smile at the woman on the bed. The man finds his way to the foot of the bed where she is lying and pulls back the covers revealing the woman's naked body. He pushes her leg as if to signal that she should raise it up and spread her legs apart. The woman on the bed must understand this because she does so. The man penetrates her body with his fingers, she cringes. She looks to her husband who is forced to bear witness to the acts being performed on his wife. Next the man at the foot of the bed requests that his woman accomplice hand him various tools and instruments, which he then begins to penetrate the woman's body with. She cries out for him to stop. She tells him that it hurts and to please stop. He tells her he knows it hurts. Then she jerks her body in reaction to the pain and discomfort his touch causes; to this, his woman accomplice is directed to hold her down. The woman in the bed is told to stay quiet, calm, and not to fight or resist the man. Without another word he leaves her again alone in the room. She has no idea what he has just done to her body. She does not know what the probes are that are now coming from her vagina are doing to her. Most of all she does not know when this man will again return to the foot of her bed again and what he will do once there. Her husband, who feels helpless, tries to ask questions of the woman accomplice. She offers him little reassurance or information and instead tells him not to worry and that he should confidently place his trust in the man who has been visiting his wife's bedside.

Hours later he enters the room again. He says he does not like what he is seeing and directs her to again spread her legs and remove the blankets which are hiding her nakedness and vulnerability. She complies. Without another word he again starts penetrating her body with his fingers. She cringes, but tries not to move; she knows resisting will only result in her being restrained again by the woman he brings with him. She again tells him he is hurting her and asks him to stop. He continues without reprieve and also threatens that if she does not comply he will cut her body open. She complies. He begins aggressively pulling on her perineum, with approximately 8 of his fingers inside her vagina. She lets out a loud yell as he pulls down. The yelling appears to be humorous to the woman accomplice and she begins to laugh that the man might hurt himself. After several moments of this and several further requests for him to stop or to be gentle from the woman in the bed the man is handed a needle. He now injects the woman's vagina, specifically this perineum area with some sort of

clear liquid. As he hands the needle back to the accomplice she then hands him surgical scissors. Again, without a word to the woman in the bed, or her husband, he cuts the woman's vagina. It bleeds significantly. He then again inserts his hands and begins pulling and tearing her open even more. Next he is handed another instrument, a large cup like device, which he proceeds to insert into the woman's body. She cries out in pain and fear, but is again reminded that she must be still and comply without complaint or it will only get worse.

What I have just described is an assault. It happens every day in labor and delivery rooms in the U.S. In fact, in some extreme and fortunately relatively rare cases, in the U.S. women have actually been legally subjected to such assaults by means of court orders (Block, 2007; Cahill, 2001). Imagine the scene described above in any context other than childbirth. It would likely be considered a violation of human rights, without hesitation, but in birth it appears to be excused based on the assumption (perception) of pathology. Cahill (2001) argued that the assumption is that such actions in birth are carried out only in the best interest of maternal and fetal outcomes and adds “Doctors who interrupt normal pregnancy are absolved from blame” (p. 340). This scene was one I witnessed while serving as a doula. The images and experiences of that night will stay with me forever.

Diane Tinker is a well-known veteran doula in central Iowa; in 2010 she contributed an essay to the book *Bearing Witness: Childbirth Stories Told by Doulas* (Doran & Caron, Eds.). Tinker titled her essay “birth in the trenches,” and described some of the common practices she bears witness to on a regular basis as a doula. The stories she shared in her essay had similar undertones to the one I have just previously shared. She writes:

It breaks my heart to see women treated this way. This woman had an overall good labor – less than 12 hours – she felt well supported and safe because she had a doula, yet she still remembers the abusive doctor when we talk about it. (p. 197)

This project has changed me; however, it is difficult to articulate the specifics of these changes. Everything I read and everyone I spoke with shaped my personal thinking and doing. How then do I even begin to attempt to sort through these experiences in my mind and make meaning from them? Following the completion of my mini-thesis project in March of 2010, I was already full of questions about the maternity culture in America. The experience with my mini-thesis project and some personal research and reflection had led me to a new understanding about childbirth. Most certainly, my perceptions have shifted.

Future Directions

It is abundantly clear that social change is necessary and must occur in America's maternity culture. Such change must encompass both our construction and performance of childbirth. It is time for us all to [re]consider and [re]evaluate who we are, how we got here, and what impact the answers to those questions have on us individually and socially. Gaining a better understanding of what may be necessary to promote the occurrence of this social change is extremely beneficial.

During my engagement in this research I was not "short" on willing participants; in fact, I actually had to turn down participants. For me, this speaks to the fact that women not only want to share about their births, but they also want a platform (a social space) to do so. I have come to understand and recognize that women want to speak about their experiences – to be heard (not silenced) – and they most certainly deserve to be validated in the process. I believe that my research project was one way for women to do this (be heard) and as such it opened the door (or floodgates) for participant referrals and participant engagement in the project. I frequently had women (non-participants and participants alike) requesting and volunteering to be involved in the project. They asked to read results or simply wanted me to

share the final product with them because they were so interested in the topic. Therefore, I believe that any forums, research, and other projects which continue to hear women's stories and privilege their voices would benefit both women and our body of knowledge alike.

Limitations

This study is limited by several factors. One factor is the small sample size. Only eight women's and four professional's stories were formally told and considered in the analysis and results of this research. Five additional participants were briefly included as well in the cohort group results. Although stories were heard in which births took place outside of the Midwest, overwhelmingly most of the births (and professional work) occurred in the central United States. Trends in birth practices as well as social attitudes and beliefs about birth vary by region (Block, 2007; Clurfeld, 2010; Declercq, 2009), which may impact the way the stories were lived and retold to me. For example, New Jersey's cesarean rate is the highest in the nation with approximately four out of 10; whereas other states remain closer to 3 out of every 10 births being a cesarean (Clurfeld; 2010; Declercq, 2009). Certainly, with any study, one should reflect on both who participates and why they participate. This study is no different.

As mentioned earlier in this study I had eager volunteers. At one point during my data collection I wrote an analytic memo reflecting on the fact that I had not one participant volunteer who had shared a specifically "negative" experience (e.g., was "angry" or had "a bone to pick"), although my recruitment flyer (Appendix A) indicated I wanted to hear from women with a "wide variety" of experiences. One could speculate as to why this might be and I will choose to leave such speculations to you, the reader. I simply offer such information for reflection and consideration.

One final consideration is the notion that this project was filtered through a specific lens – the feminist lens. As indicated, this factor influenced the project from start to finish. For example, it influenced the research questions I asked and the questions I asked women. Certainly it influenced the themes I found, since it would have been possible to find any number of themes, depending on how one went about sorting and thinking about the data. It definitely influenced the literature review and the studies I selected to use as comparison studies and the books I read as I did this research.

Final Thoughts

To be clear, I do not think, feel, or believe that medicine or the medical model is “bad,” that all women should birth at home with midwives, or that women should think, feel, or believe their births to be anything less than what is true for them.

What I struggle with is the question, “So what now?” The fact is, I cannot turn back the clocks – hit a reset button – in order to re-construct or redefine birth. This is our history, America. This is our collective birth story. We must recognize it and validate it for what it is, whatever this might mean for you is for you to define; however, first we must acknowledge it. What I have attempted to challenge here, with this entire project, is the status quo – our dominant way of knowing (and doing) regarding birth in this country. The hope and goal of this is to present you, the reader, with a potential alternative to what you may have thought, known, or believed to be true regarding our birth practices in this country and, simply put, how we got here. My greatest desire is that the information I have provided has challenged you, and your thinking and doing, and in turn may begin to change the culture.

With information and education comes power, which can influence the future construction and definition of birth for the next generations. It is my sincere hope and passion to share with women what I have learned – to empower them, as Paige said, “to define for themselves” what their birth experiences can be and what they mean for them-- to have fewer women say “I don’t know why” or “It’s just what you do” when describing their deeply personal, life-changing, childbirth experiences. It is my belief that without education and information, women are not able to define for themselves and therefore, birth remains defined for them. This goal also means accepting that some women disagree with me. Some women do not see the birth culture in America is hegemonic and do not feel disempowered – and that is their right. I recognize this stance and value it as I do any other perspective.

The great physicist, Albert Einstein, is quoted as having said, “You cannot solve problems with the same thinking that created those problems.” I believe that in order to see a cultural shift, social change, in the maternity culture, our collective thinking about birth (and women) must change. The line of thought that led us to this point included notions of women’s bodies as broken, women as a weaker sex, and that technology (at the hands of skilled men) could rescue women from nature’s shortcomings. All four of the professional participants in this project, and a few of the women participants, mentioned (with varying degrees of concern) a *need* for systemic change in maternity care. If these changes are to occur, and I unquestionably agree that they are fully necessary, I believe that starting with the empowerment of women to know and believe in their body’s (physical and emotional) capability to give birth is a potent place to begin.

Just imagine if we started today telling the next generation of women (the littlest of girls now) that their bodies are beautiful and not broken, that their minds are strong and not

weak, that they are made just how nature intended them to be – to start telling them now, what so many of the participants in this study longed to have heard, that they *can* do it and that they are *okay!* We need to begin building a village and providing that support to them now. We could address the messages that the media are sending about birth and instead begin showing birth in a positive way. Many participants noted the role of the media in both creating and spurring on their fears about birth, only to then report the actual experience of their birth as “not that bad.” Clearly, the media is impacting this distorted perception and should not be underestimated as a powerhouse of social change. What if we began to show and spread the message of birth as not that bad? What would the picture of maternity culture be in 20 years if we started doing that today? Instead of spreading fear and isolation, technology, industry, and management we would spread positive messages including encouragement, support, and capability. It is not difficult to conceive the powerful trickle down (and up) affects such small and simple changes would make. This generation of girls (the babies now) will soon be consumers and as such will have a powerful and influential voice. We have the power to impact those voices such that they be ones of change!

I close this momentous and pivotal chapter in my life with three quotes which I have found to be encouraging. I carry them with me as I move to the next phase – moving these words, these thoughts, these dreams into action – and I offer them to you now as closing thoughts.

“With the will and the skill, we can seize these opportunities to enhance the well-being of mothers, babies and families” Declercq et al., 2007, p. 14.

“Be the change you want to see in the world” Mahatma Gandhi.

“Nothing great has been and nothing great can be accomplished without passion” Hegel.

REFERENCES

- Ainsworth, M. D. S. (1969). Object relations, dependency and attachment: A theoretical review of infant-mother relationship. *Child Development*, 40, 969-1025.
- Ainsworth, M. D. S., Bell, S. M., & Stayton, D. J. (1971). Individual differences in strange situation behavior of one-year-olds. In H.R. Schafer (Ed.), *The Origins of Human Social Relations* (pp. 17-57). New York: Academic.
- Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978). *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.
- Ainsworth, M. D. S. (1991). Attachment and other affectional bonds across the life cycle. In C. M. Parkes, J. Stevenson-Hinde, & P. Marris (Eds.), *Attachment across the life cycle* (pp. 33-51). New York: Routledge.
- Anema, J., Morey, A., McAninch, J., Mario, L., & Wessells, H. (2000). Complications related to the high lithotomy position during urethral reconstruction. *The Journal of Urology*, 164(2), 360-363.
- Anfara, V. A., & Mertz, N. T. (2006). *Theoretical frameworks in qualitative research*. Thousand Oaks, CA: Sage.
- Axness, M. (2007). When the joy of the mother is missing – an organic perspective on postpartum depression. *Journal of prenatal and perinatal psychology and health*, 21(4), 315-319.
- Baker, M. (2005). Childbirth practices, medical intervention and women's autonomy: Safer childbirth or bigger profits? *Women's Health and Urban Life*, 4(2), 27-44.
- Baker, S. J. (1939). *Fighting for life*. New York, NY: The Macmillan Company.
- Barr, J. A. (2008). Postpartum depression, delayed maternal adaptation, and mechanical infant caring: A phenomenological hermeneutic study. *International Journal of Nursing Studies*, 45, 362-269.
- Bayes, S., Fenwick, J., & Hauck, Y. (2008). A qualitative analysis of women's short accounts of labour and birth in a Western Australia public tertiary hospital. *Journal of Midwifery and Women's Health*, 53, 53-61.
- Beckett, K. (2011). Choosing cesarean: Feminism and the politics of childbirth in the United States. *Feminist Theory*, 6(3), 251-275.
- Beecher, C. E., Stowe, H. B., & Tonkovich, N. (Ed.) (2002). *The American woman's home*. New Brunswick, NJ: Rutgers University.

- Benoit, D. (2002). Parenting infants: What really matters in the first years of life? IMPrint-The attachment collection. *Newsletter of the Infant Mental Health Promotion Project*, Special Issue, January, 9-10.
- Bernier, A., Jarry-Boileau, V., Tarabulsky, G. M., & Miljkovitch, R. (2010). Initiating a caregiving relationship: Pregnancy and childbirth factors as predictors of maternal sensitivity. *Infancy*, 15(2), 197-208.
- Bifulco, A., Figueiredo, B., Guedeney, G., Gorman, L. L., Hayes, S., Muzik, M., & Henshaw, C. A. (2004). Maternal attachment style and depression associated with childbirth: Preliminary results from a European and US cross-cultural study. *Birth*, 184(Suppl. 46), s31-s37.
- Block, J. (2007). *Pushed: The painful truth about childbirth and modern maternity care*. Cambridge, MA: De Capo.
- Bloom, L. R. (1998). *Under the sign of hope: Feminist methodology and narrative interpretation* Albany, NY: SUNY.
- Bloomberg, L. D., & Volpe, M. (2008). *Completing your qualitative dissertation: A roadmap from beginning to end*. Thousand Oaks, CA: Sage.
- Bowlby, J. (1969). *Attachment and loss, Vol. 1*. London: Hogarth.
- Bowlby, J., Ridgeway, D., & Cassidy, J. (1990). Assessing internal working models of the attachment relationship: An attachment story completion task for 3-year-olds. In M.T. Greenberg, D. Cicchetti, & E.M. Cummings (Eds.), *Attachment in the preschool years* (pp. 273-308). Chicago, IL: University of Chicago.
- Brotherson, M. J. (2009). Philosophical assumptions of qualitative research. Presentation notes, Human Development and Family Studies 504: Qualitative Methods. Iowa State University, September 9.
- Brown, L., & Strega, S. (2005). *Research as resistance: Critical, indigenous, and anti-oppressive approaches*. Toronto, Canada: Canadian Scholars.
- Bryanton, J., Gagnon, A. J., Hatem, M., & Johnston, C. (2009). Does perception of the childbirth experience predict women's early parenting behaviors? *Research in Nursing and Health*, 32, 191-203.
- Buckley, S. J. (2002). The hormonal blueprint of labor. *Ecstatic Birth*, 111(March/April). Retrieved from <http://mothering.com/pregnancy-birth/ecstatic-birth-the-hormonal-blueprint-of-labor>, March 2009.

- Butler, N., & Bonham, D. (1963). *Perinatal mortality*. Edinburgh: Churchill Livingstone.
- Cahill, H. A. (2001). Male appropriation and medicalization of childbirth: A historical analysis. *Journal of Advanced Nursing*, 33(3), 334-342.
- Callister, L. C., Khalaf, I., Semenic, S., Kartchner, R., & Vehvilainen-Julkunen, K. (2003). The pain of childbirth: Perceptions of culturally diverse women. *Pain Management Nursing*, 4(4), 145-154.
- Canadian Child Care Federation and Canadian Institute of Child Health. (2001). *What we know about the brain*. Ottawa, Ontario, England: Author.
- Chalidze, L. L. (2009). Misinformed consent: Non-medical bases for American birth recommendations as a human rights issue. *New York Law School Review*, 54, 59-103.
- Chalmers, B., Mangiaterra, V., & Porter, R. (2001). WHO principles of perinatal care: The essential antenatal, perinatal, and postnatal care course. *Birth*, 28(3), 202-207.
- Chang, P., Thompson, T. R., & Fisch, R. O. (1982). Factors affecting attachment between infants and mothers separated at birth. *Development and Behavioral Pediatrics*, 3(2), 96-98.
- Channing, W. (1849). *A treatise on etherization in childbirth, illustrated by 581 cases*. Boston, MA: Ticknor.
- Channing, W. (n.d.), Selected works. In Kass (2002). *Midwifery and Medicine in Boston*. Richmond, VA: Northeastern University.
- Charmaz, K. (2006). *Constructing grounded theory*. Thousand Oaks, CA: Sage.
- Cleeton, E. R. (2001). Attitudes and beliefs about childbirth among college students: Results of an educational intervention. *Birth*, 28(3), 192-201.
- Clurfeld, A. (2010, May 23). Special deliveries: Why are so many Jersey moms having c-sections? *Asbury Park Press*, pp. A1, A6, A7.
- Condon, J. T., & Dunn, D. J. (1987). Nature and determinants of parent-to-infant attachment in the early postnatal period. *Journal of the American Academy of Child Adolescent Psychiatry*, 27(3), 293-299.
- Cohen, S. A., & Hurt, W. G. (2001). Compartment syndrome associated with lithotomy position and intermittent compression stockings. *Obstetrics & Gynecology*, 97, 832-833.

- Cox, S. M., Hopkins, J., & Hans, S. L. (2000). Attachment in preterm infants and their mothers: neonatal risk status and maternal representations. *Infant Mental Health Journal*, 21(6), 464-480.
- Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.
- Creswell, J. W. (2002). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research*. Upper Saddle River, NJ: Merrill.
- Crotty, M. (2003). *The Foundations of social research: Meaning and perspective in the research process*. Thousand Oaks, CA: Sage.
- Curry, D. (2009). Health findings: The latest public health studies and research. *The Nations Health*(March). American Public Health Association.
- Danzinger, S. K. (1986). Male doctor – female patient. In P.S. Eakins (Ed.), *The American way of birth* (pp. 119-141). Philadelphia, PA: Temple University.
- Darra, S. (2009). ‘Normal’, ‘natural’, ‘good’ or ‘good enough’ birth: Examining the concepts. *Nursing Inquiry*, 16(4), 297-305.
- Davis-Floyd, R. (1987). Obstetric practice as a rite of passage. *Special Issue of the Medical Anthropology Quarterly*, 1(3): 288-318.
- Davis-Floyd, R. (1994). The technocratic body: American childbirth as cultural expression. *Social Science Medicine*, 38(8), 1125-1140.
- Davis-Floyd, R., & Johnson, C. B. (2006). *Mainstreaming midwives: The politics of change*. New York, NY: Routledge.
- Davenport, E. P. (2010). Court Ordered Cesarean Sections: Why Courts Should Not Be Allowed to Use a Balancing Test. *Duke Journal of Gender Law & Policy*, 18(1), 79-103.
- Dawley, K. (2000). The campaign to eliminate the midwife. *The American Journal of Nursing*, 100(10), 50-56.
- DeLee, J. B. (1920). The prophylactic forceps operation. *American Journal of Obstetrics and Gynecology*, 1, 34-44.
- Declercq, E. R. (1992). The transformation of American midwifery: 1975 to 1988. *American Journal of Public Health*, 82(5), 680-684.

- Declercq, E. R., Sakala, C., Corry, M. P., & Applebaum, S. (2007). Executive summary, childbearing experiences. *The Journal of Perinatal Education*, 16(4), 9-14.
- Declercq, E. R., Sakala, C., Corry, M.P., & Applebaum, S. (2008). New mothers speak out: National survey results highlight women's postpartum experiences. New York: Childbirth Connection, August.
- Declercq, E. R. (2009). *Birth by the numbers*. Video presentation created July 2009, accessed March, 2010 at www.orgasmicbirth.com/bythenumbers.
- Dick-Read, G. (1944). *Childbirth without fear*. New York, NY: Harper & Row.
- Dominguez-Bello, M. G., Costello, E. K., Contreras, M., Magris, M., Hidalgo, G., Fierer, N., & Knight, R. (2010). Delivery mode shapes the acquisition and structure of the initial microbiota across multiple body habitats in newborns. *Proceedings of the National Academy of Science*, 107(26), 11971-11975.
- Dye, N. S. (1986). The medicalization of birth. In P.S. Eakins (Ed.), *The American way of birth* (pp. 21-46). Philadelphia, PA: Temple University.
- Eakins, P. S. (Ed.) (1986). *The American way of birth*. Philadelphia, PA: Temple University.
- Edhborg, M., Matthiesen, A. S., Lundh, W., & Widstrom, A. M. (2005). Some early indicators for depressive symptoms and bonding 2 months postpartum – A study of new mothers and fathers. *Archives of Women's Mental Health*, 8, 221-231.
- Emerson, W. R. (1998). Birth trauma: The psychological effects of obstetrical interventions. *Journal of Prenatal and Perinatal Psychology and Health*, 13(1), 11-19.
- Epstein, A. (Director). (2007). *The business of being born* [film]. Los Angeles, CA: Red Envelope Entertainment.
- Epstein, R. H. (2010). *Get me out of here: The history of childbirth from the Garden of Eden to the sperm bank*. New York, NY: W.W. Norton.
- Eyer, D. E. (1994). Mother-infant bonding. *Human Nature*, 5(1), 69-94.
- Fenwick, J., Gamble, J., & Hauck, Y. (2006). Reframing birth: a consequence of cesarean section. *Journal of Advanced Nursing*, 56(2), 121-132.
- Fenwick, J., Gamble, J., Nathan, E., Bayes, S., & Hauck, Y. (2009). Pre- and postpartum levels of childbirth fear and the relationship to birth outcomes in a cohort of Australian women. *Midwifery and Maternal Health*, 18, 667-677.

- Fisher, C., Hauck, Y., & Fenwick, J. (2006). How social context impacts on a women's fears of childbirth: A Western Australian example. *Social Science and Medicine*, 63, 64-75.
- Foucault, M. (1973, trans.). *The birth of the clinic*. Bungay, Suffolk: Tavistock Publication Limited.
- Friedrich, L.P. (1939). I Had a Baby. *Atlantic Monthly*(April), 461-65.
- Funai, E. F., & Norwitz, E. R. (2010). Mechanism of normal labor. Up To Date. Retrived at: <http://www.uptodate.com/patients/content/topic.do?topicKey=~82731/ledrobal3>, June 2010.
- Gamble, J., Greedy, D., & Moyle, W. (2004). Counselling process to address psychological distress following childbirth: perceptions of midwives. *Australia Midwifery*, 17(3), 16-19.
- Gaskin, I. M. (2003). *Ina May's guide to childbirth*. New York, NY: Bantam Dell.
- Glesne, C. (2006). *Becoming qualitative researchers: An introduction (3rd Ed.)*. Boston, MA: Pearson.
- Glaser, B. G., & Strauss, A.L. (1967). *The discovery of grounded theory*. Chicago, IL: Aldine.
- Goer, H. (1999). *The thinking woman's guide to a better birth*. New York, NY: Berkley.
- Goldberg, S., Muir, R., & Kerr, J. (1995). *Attachment theory: Social, developmental, and clinical perspectives*. Hillsdale, NJ: Analytic.
- Guba, E.G., & Lincoln, Y. S. (1998). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The landscape of qualitative research* (pp. 195–220). London, England: Sage.
- Hall, W. A., Hauck, Y., Carty, E. M., Hutton, E. K., Fenwick, J., & Stoll, K. (2009). Childbirth fear, anxiety, fatigue, and sleep deprivation in pregnant women. *Journal of Obstetric and Gynecological Neonatal Nurses*, 38, 567-576.
- Hallgren, A., Kihlgren, M., Norberg, A., & Forslin, L. (1995). Women's perceptions of childbirth and childbirth education before and after education and birth. *Midwifery*, 11, 130-137.
- Harding, S. (1987). Is there a feminist method? In S. G. Harding (Ed.), *Feminism and methodology: Social science issues* (pp. 1-17). Bloomington, IN: Indiana University.

- Hardy, A. (2010). Maternal perceptions and experiences with pregnancy and childbirth. Paper written as a mini-thesis, Department of Human Development and Family Studies, Iowa State University, Ames, IA.
- Heath, P. (2005). *Parent-child relations: History, theory, research, and context*. Upper Saddle River, NJ: Pearson Education.
- Hauck, Y., Fenwick, J., Downie, J., & Butt, J. (2007). The influence of childbirth expectation on Western Australian women's perceptions of their birth experience. *Midwifery*, 23, 235-247.
- Heinze, S. D., & Sleight, M. J. (2003). Epidural or no epidural anesthesia: Relationships between beliefs about childbirth and pain control choices. *Journal of Reproductive and Infant Psychology*, 21(4), 323-333.
- Hickman, A. (2010). Born (not so) free: legal limits on the practice of unassisted childbirth or freebirthing in the United States. *Minnesota Law Review*, 94(5), 1651-1681.
- Hjelmstedt, A., Widstrom, A., & Collins, A. (2006). Psychological correlates of prenatal attachment in women who conceived after in vitro fertilization and women who conceived naturally. *Birth*, 33(4), 303-310.
- Hoehn-Saric, R. (2004). Patients with anxiety disorders more sensitive to bodily changes. *Archives of General Psychiatry*, 61, 913-921.
- Hofberg, K., & Brockington, I. (2000). Tokophobia: An unreasoning dread of childbirth. *British Journal of Psychiatry*, 176, 83-85.
- Hofberg, K., & Ward, M. R. (2010). Fear of pregnancy and childbirth. *Postgrad Medical Journal*, 79, 505-510.
- Holland, E. (1935). Maternal Mortality. *Lancet*, 27(April), 973-976.
- Inch, S. (1981). *Birthrights*. London, England: Hutchinson
- Italie, L. (2011). Home birth on the rise by a dramatic 20 percent. *Associated Press*, Tuesday July 5, 2011.
- Janssen, P. A., Henderson, A. D., & Vedam, S. (2009). The experience of planned home birth: Views of the first 500 women. *Birth*, 36(4), 297-304.
- Johanson, R., Newburn, M., & Macfarlane, A. (2002). Has the medicalisation of childbirth gone too far? *British Medical Journal*, 324(7244), 892-895.

- Johnson, K. C., & Daviss, B. (2005). Outcomes of planned home birth with certified professional midwives: Large prospective study in North America. *British Medical Journal* 330(7505), 1416-1422 .
- Jordan, B. (1980). Birth in four cultures: *A crosscultural investigation of childbirth in Yucatan, Holland, Sweden, and the United States*. Montreal, Canada: Eden Press.
- Jordan, B. (1990). Technology and the social distribution of knowledge. In Coreil, J. Mull, D. (Eds.) *Anthropology and Primary Health Care*. Boulder, CO: Westview.
- Kaitz, M., Zvi, H., Levy, M., Berger, A., & Eidelman, A. I. (1995). The uniqueness of mother-own-infant interactions. *Infant Behavior and Development*, 18, 247-252.
- Karen, R. (1994). *Becoming attached: First relationships and how they shape our capacity to love*. New York: Oxford University.
- Karlstrom, A., Radestad, I., Eriksson, C., Rubertsson, C., Nystedt, A., & Hildingsson, I. (2010). Cesarean section without medical reason, 1997 to 2006: A Swedish register study. *Birth*, 37(1), 11-20.
- Kass, A. M. (2002). *Midwifery and medicine in Boston: Walter Channing, M.D. 1786-1876*. Boston, MA: Northeastern University.
- Kitzinger, S. (2011). Human rights and midwifery. *Birth*, 38(1), 86-87.
- Klaus, M. H., Jerauld, R., Kreger, N. C., McAlpine, W., Steffa, M., & Kennell, J. H. (1971). Maternal attachment: Importance of the first post-partum days. *The New England Journal of Medicine*, 286(9), 460-463.
- Klaus, M. H., & Kennell, J. H. (1976). The bonding bind: Maternal-infant bonding, the impact of early separation or loss on family development. *Contemporary Psychology*, 22, 486-487.
- Klein, M. C. (2005). Obstetrician's fear of childbirth: How did it happen? *Birth*, 32(3), 207-209.
- Knoche, A., Selzer, C., & Smolley, K. (2008). Methods of stimulating the onset of labor: An exploration of maternal satisfaction. *Journal of Midwifery & Women's Health*, 53(4), 381-387.
- Knuuttila, S. (2008). Aristotle's theory of perception and medieval Aristotelianism. *Theories of perception in medieval and early modern philosophy*, 6, 1-22, DOI: 10.1007/978-1-4020-6125-7_1.

- Kung H.C., Hoyert, D.L., Xu, J.Q., & Murphy, S. L. (2008). *Deaths: Final data for 2005. National vital statistics reports, 56*(10). Hyattsville, MD: National Center for Health Statistics.
- Lather, P. (1992). Critical frames in educational research: Feminist and post-structural perspectives. *Theory and practice, 31*(2), 87-99.
- Laursen, M., Hedegaard, M., & Johansen, C. (2007). Fear of childbirth: Predictors and temporal changes among nulliparous women in the Danish national birth cohort. *British Journal of Obstetrics and Gynaecology, 115*, 354-360.
- Leavitt, J. W., Ed. (1984). *Women and health in America*. Madison, WI: Wisconsin University.
- Leavitt, J. W. (1986a). "Science" enters the birthing room: Obstetrics in America since the eighteenth century. *Journal of American History, 70*(2), 281-304.
- Leavitt, J. W. (1986b). *Brought to bed: Childbearing in America 1750-1950*. New York, NY: Oxford University.
- Leavitt, J. W. (1988). Joseph B. DeLee and the practice of preventative obstetrics. *American Journal of Public Health, 78*(10), 1353-1360.
- Lee, J. K., Hecht, M., Miller-Day, M., & Elek, E. (2011). Evaluating Mediated Perception of Narrative Health Messages: The Perception of Narrative Performance Scale. *Communication Methods and Measures, 5*(2), 126-145.
- Lindgren, Y. F. (2011). The emotional woman and her objective doctor: Clinical discretion and court-enforced gender ideology. [unpublished manuscript]. University of California – Berkely.
- Lilienthal, E. R. (1983). *Psychological aspects of cesarean delivery: A family study*. Ph.D. Dissertaion. George Washington University, United States – Washington D.C., Retrieved March 10, 2010, from Dissertations & Theses: A&I (Publication No. 11411979).
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- Lothian, J. A. (2009). Ethics and maternity care: From principle to practice. *Journal of perinatal education, 18*(1), 1-3.
- MacDorman, M. F., Declercqu, E., & Menacker, F. (2011). Trends and characteristics of home births in the United States by race and ethnicity, 1990-2006. *Birth, 38*(1), 17-23.

- Madison, S. D. (2005). *Critical ethnography: Methods, ethics, and performance*. Thousand Oaks, CA: Sage.
- Martell, J. (2008). *The history of childbirth – Ouch!* Thehistoryof.net, accessed July 2010 at <http://www.thehistoryof.net/history-of-childbirth.html>
- Maxwell, J. A. (2005). *Qualitative research design: An interactive approach*. Thousand Oaks, CA: Sage.
- McMahon, C. A., Barnett, B., Kowalenko, N. M., & Tennant, C. C. (2006). Maternal attachment state of mind moderates the impact of postnatal depression on infant attachment. *Journal of Child Development and Psychiatry*, 47(7), 660-669.
- McLaren, L., Kuh, D., Hardy, R., & Mishra, G. (2007). Postnatal depression and the original mother-child relationship: A prospective cohort study. *Journal of Affective Disorders*, 100, 211-219.
- Mead, M. (1972). *Blackberry winter: My early years*. New York, NY: Kodansha International.
- Meigs, G. L. (1986) Maternal mortality for all conditions connected with childbirth. In J.B. Litoff (Ed.), *The American midwife debate: a sourcebook on its modern origins*(50-66). New York, NY: Greenwood.
- Melender, H. (2002). Experiences of fears associated with pregnancy and childbirth: A study of 329 pregnant women. *Birth*, 29(2), 101-111.
- Menacker, F., & Hamilton, B. E. (2010) Recent trends in cesarean delivery in the United States. *NCHS data brief*, no 35. Hyattsville, MD: National Center for Health Statistics.
- Mercer, R.T. (1986). *First-time motherhood: Experiences from teens to forties*. New York: Springer.
- Mercer, R. T., & Ferketich, S. L. (1994). Maternal-infant attachment of experienced and inexperienced mothers during infancy. *Nursing Research*, 43, 344-351.
- Merkin, D. H. (1976). *Pregnancy as a disease*. Port Washington, NY: National University, Kennikat.
- Merriam, S. B. (2002). *Qualitative research in practice: Examples for discussion and analysis*. San Francisco, CA: Jossey-Bass.
- Merriam-Webster's Online Dictionary (2011). Accessed February 4, 2011 at www.m-w.com

- Miller, K. (2009). *Developmental attachment psychotherapy*. Conference proceedings.
- Milliken, L. D. (2004). Cesarean birth stories. *Journal of Pre-and Perinatal Psychology and Health*, 22(2), 129-146.
- Minde, K., & Hesse, E. (1996). The role of the adult attachment interview in parent-infant psychotherapy: A case presentation. *Infant Mental Health Journal*, 17(2), 115-126.
- Mitchell, S. W. (1904). The evolution of the rest treatment. *Journal of Nervous and Mental Disease*, 31(6), 368-373.
- Moburg, B. J. (1981). *The relationship between the quality of a woman's childbirth experience and the patterns of mother-infant attachment*. Ph.D. dissertation, Southern Illinois University at Carbondale, United States -- Illinois. Retrieved September 21, 2010, from Dissertations & Theses: A&I (Publication No. AAT 8206477).
- Morantz, R. (1974). The lady and her physician. In M. Hartman, & L.W. Banner (Eds.), *Clio's consciousness raised: New perspectives of women*. New York, NY: Harper & Row.
- Morison, S., Hauck, Y., Percival, P., & McMurray, A. (1998). Constructing a home birth environment through assuming control. *Midwifery*, 14, 233-241.
- Morison, S., Percival, P., Hauck, Y., & McMurray, A. (1999). Birth at home: The resolution of expectations. *Midwifery*, 15, 32-39.
- Morton, S. C., Williams, M. S., Keeler, E. B., Gamone, J. C. & Kahn, K. L. (1994). Effect of epidural analgesia for labor on the cesarean delivery rate. *Obstetrics and Gynecology*, 83(6), 1045-1052.
- Mulholland, J., & Wallace, J. (2003). Facilitating primary science teaching: A narrative account of research as learning. *Teachers and Teaching: Theory and Practice*, 9(2), 133-155.
- National Vital Statistic System (NVSS) Osterman, M. J. K., & Martin, J. A. (2008). Epidural and spinal anesthesia use during labor: 27-state reporting area. *National vital statistics reports*, 59(5), 1-16.
- Nerum, H., Halvorsen, L., Sorlie, T., & Oian, P. (2006). Maternal request for cesarean section due to fear of birth: Can it be changed through crisis-oriented counseling? *Birth*, 33(3), 221-228.

- New York Academy of Medicine Committee on Public Health Relations, Maternal mortality in New York City: A study of all puerperal deaths, 1930-1932 (New York, 1933), p. 32-186.
- Olde, E., van der Hart, O., Kleber, R., & van Son, M. (2005). Posttraumatic stress following childbirth: A review. *Clinical Psychology Review*, 26, 1-16.
- Oliver, R. J. (2004). Sharing space: Obstetrics and attachment. *Journal of Prenatal and Perinatal Psychology and Health*, 19(2), 169-173.
- O'Reilly, A. (2004). *From motherhood to mothering: The legacy of Adrienne Rich's Of Woman Born*. Albany, NY: State University of New York.
- Patton, M. Q. (1985). Quality in qualitative research: Methodological principles and recent developments. Invited address to Division Journal of the American Educational Research Association, Chicago.
- Pavlova, M., Hendrix, M., Nouwens, E., Nijhuis, J., & van Merode, G. (2009). The choice of obstetric care by low-risk pregnant women in the Netherlands: Implications for policy and management. *Health Policy*, 93, 27-33.
- Perry, B. (2001). *Bonding and attachment in maltreated children: Consequences of emotional neglect in childhood*. New York, NY: The Child Trauma Academy.
- Pollock, D. (1999). *Telling bodies performing birth*. New York, NY: Columbia University.
- Prasad, P. (2005). *Crafting qualitative research; Working in the postpostivist traditions*. Armonk, NY: M. E. Sharpe.
- Priel, B., & Besser, A. (2000). Adult attachment styles, early relationships, antenatal attachment, and perceptions of infant temperament: A study of first-time mothers. *Personal Relationships*, 7, 291-310.
- Redshaw, M., Martin, C., Rowe, R., & Hockley, C. (2009). The Oxford worries about labour scale: Women's experience and measurement characteristics of a measure of maternal concern about labour and birth. *Psychology, Health & Medicine*, 14(3), 354-366.
- Rich, A. (1976). *Of woman born: Motherhood as experience and institution*. New York, NY: W.W. Norton.
- Reiger, K., & Dempsey, R. (2006). Performing birth in a culture of fear: An embodied crisis of late modernity. *Health Sociology Review*, 15(4), 364-373.
- Reyes, J. W. (2007). Gender and labor market outcomes: Reaching equilibrium in the market for obstetricians and gynecologists. *AEA Papers and Proceedings*, 97(2), 407-411

- Roberts, J. (2006). Alternative positions for childbirth-part II: second stage of labor. *Journal of Nurse-Midwifery*, 25(5), 13-19.
- Rothman, B. K. (1982). *In labor: Women and power in the birthplace*. New York, NY: W.W. Norton.
- Rothman, B. K. (1986a). *The social construction of birth*. In Eakins, P. S. (Ed.), *The American way of birth* (pp. 104-118). Philadelphia, PA: Temple University.
- Rothman, B. K. (1986b). *The tentative pregnancy*. New York, NY: Viking Penguin.
- Rothman, B. K. (1989). *Recreating motherhood: Ideology and technology in a patriarchal society*. New York, NY: W. W. Norton.
- Rothman, B. K. (Ed.) (1993). *Encyclopedia of childbearing: Critical perspectives*. Phoenix, AZ: Oryx.
- Rouche, H., Salmela-Aro, K., Halmesmaki, E., & Saisto, E. (2008). Fear of childbirth according to parity, gestational age, and obstetric history. *British Journal of Obstetrics and Gynaecology*, 116, 67-73.
- Saisto, T., Kaaja, R., Ylikorkala, O., & Halmesmaki, E. (2001). Reduced pain tolerance during and after pregnancy in women suffering from fear of labor. *International Association for the Study of Pain*, 93, 123-127.
- Saisto, T., Salmela-Aro, K., Nurmi, J., & Halmesmaki, E. (2001). Psychosocial characteristics of women and their partners fearing vaginal childbirth. *British Journal of Obstetrics & Gynaecology*, 108, 492-498.
- Saisto, T., & Halmesmaki, E. (2003). Fear of childbirth: A neglected dilemma. *Acta Obstetrica et Gynecologica Scandinavica*, 82, 201-208.
- Sakala, C. (2006). Why do women go along with this stuff? Women don't know what they don't know. *Birth*, 33(3), 246-247.
- Saldana, J. (2009). *The coding manual for qualitative researchers*. Thousand Oaks, CA: Sage
- Scelfo, J. (2008). Baby, you're home. *New York Times*, November.
- Schram, C. (2009). Maternal history. *Canadian family physician*, 55(August), 787-788.
- Scully, D. (1986). From natural to surgical event. In P.S. Eakins (Ed.), *The American way of birth* (pp. 47-59). Philadelphia, PA: Temple University.

- Scully, D. (1994). *Men who control women's health: The miseducation of obstetrician-gynecologists*. New York, NY: Houghton Mifflin.
- Searle, J. (1996). Fearing the worst – why do pregnant women feel ‘at risk’? *Australia and New Zealand Journal of Obstetrics and Gynaecology*, 36(3), 279-286.
- Simkin, P. (2006). Why do women go along with this stuff?: “It is not quite that simple...” *Birth* 33(3), 247-249.
- Society of Obstetricians and Gynaecologists of Canada et al. (2008). Joint Policy Statement on Normal Childbirth. *Journal of Obstetrics and Gynaecology Canada*, 30(12), 1163-1165.
- Sorenson, D. S., & Tschetter, L. (2009). Prevalence of negative birth perception, disaffirmation, perinatal trauma symptoms, and depression among postpartum Women. *Perspectives in Psychiatric Care*, 46(1), 14-25.
- Spice, K., Jones, S. L., Hadjistavropoulos, D., Kowalyk, K., & Stewart, S. (2009). Prenatal fear of childbirth and anxiety sensitivity. *Journal of Psychosomatic Obstetrics and Gynecology*, 30(3), 168-174.
- Stockill, C. (2007). Trust the experts? A commentary on choice and control in childbirth. *Feminism & Psychology*, 17(4), 571-577.
- Stoll, K., Fairbrother, N., Carty, E., Jordan, N., Miceli, C., Vostreil, Y., & Willihnganz, L. (2009). “It’s all the rage these days”: University students’ attitudes toward vaginal and cesarean birth. *Birth*, 36(2), 133-140.
- Sugarman, M. (1977). Paranatal influences on maternal-infant attachment. *American Journal of Orthopsychiatry*, 47(3), 407-421.
- Suskind, R. (2006). *The one percent doctrine*. New York, NY: Simon and Schuster.
- Swain, J. E., Tasgin, E., Mayes, L. C., Feldman, R., Constable, R. T., & Leckman, J. F. (2008). Maternal brain response to own baby-cry is affected by cesarean section delivery. *The Journal of Child Psychology and Psychiatry*, 49(10), 1042-1052.
- Tejada-Vera, B., & Sutton P.D. (2010) Births, marriages, divorces, and deaths: Provisional data for July 2009. *National vital statistics reports*, 58(15). Hyattsville, MD: National Center for Health Statistics.
- Tew, M. (1998). *Safer childbirth? A critical history of maternity care* (3rd Ed.). New York, NY: Free Association.

- Thomas, R. M. (2005). *Comparing theories of child development* (6th ed.). Belmont, CA: Thomson Wadsworth.
- Tinker, D. (2010). Birth in the trenches. In L. Doran & L. Caron (Eds.), *Bearing witness: Childbirth stories told by doulas* (pp. 191-197). Kingston, Ontario, Canada: Fox Women's Books.
- Towler, J., & Bramall, J. (1986). *Midwives in history and society*. Dover, NH: Croom Helm.
- Trevathan, W. R. (1993). The evolutionary history of childbirth: Biology and cultural practices. *Human Nature*, 4(4), 337-350.
- United Nations Children's Fund (UNICEF) (2008). *State of the world's children 2009: Maternal and newborn health*. New York, NY: UNICEF.
- Van den Bussche, E., Crombex, G., Eccleston, C., & Sullivan, M. J. L. (2006). Why women prefer epidural analgesia during childbirth: The role of beliefs about epidural analgesia and pain catastrophizing. *European Journal of Pain*, 11, 275-282.
- Vieten, C., & Astin, J. (2008). Effect of a mindfulness-based intervention during pregnancy on prenatal stress and mood: Results of a pilot study. *Archives of Women's Mental Health*, 11, 67-74.
- Wagner, M. (2001). Fish can't see water: The need to humanize birth. *International Journal of Gynecology and Obstetrics*, 75, 25-37.
- Waldenstrom, U. (1999). Experience of labor and birth in 1111 women. *Journal of Psychosomatic Research*, 47(5), 471-482.
- Waldenstrom, U., Hildingsson, I., Rubertsson, C., & Radestad, I. (2004). A negative birth experience: Prevalence and risk factors in a national sample. *Birth*, 31(1), 17-27.
- Waldenstrom, U. (2004). Why do some women change their opinion about childbirth over time? *Birth*, 31(2), 102-107.
- Waters, J. L. (2011). In whose best interest? New Jersey division of youth and family services v. V.M. and B.G. and the next wave of court-controlled pregnancies. *Harvard Journal of Law & Gender*, 34, 81-111.
- Wengraf, T., 2001. *Qualitative research interviewing: biographic narrative and semi-structured methods*. London: Sage.
- Wertz, R., & Wertz, D. (1989). *Lying-In: A History of childbirth in America*. New Haven, CT: Yale University.

- White House Conference on Child Health and Protection, Fetal, newborn, and maternal mortality and morbidity (New York, 1933), pp. 215-217.
- Wiegers, T. A., Van Der Zee, J., Kerssens, J. J., & Keirse, M. J. N. C. (1998). Home birth or short-stay hospital birth in a low risk population in the Netherlands. *Social Science Medicine*, 46(11), 1505-1511.
- Wood, A. D. (1974). The fashionable diseases: Women's complaints and their treatment in the nineteenth century America. In M. Hartman and L.W. Banner (Eds.), *Clio's consciousness raised: New perspective on the history of women*. New York, NY: Harper & Row.
- World Health Organization (WHO). (1985a) Appropriate technology for birth. *Lancet*, 2, 436-437.
- World Health Organization (WHO). (1985b). *Having a baby in Europe: Report on a study*. Denmark: Company Self-Publication.
- World Health Organization (WHO). (1996). *Safe Motherhood: Care in normal birth*. Geneva Switzerland: Company Self-Publication.
- World Health Organization (WHO). (2000). Improving maternal health is one of the eight Millennium Development Goals adopted by the international community at the United Nations Millennium Summit in 2000 (WHO, <http://www.who.int/reproductive-health/publications.html>, July 12, 2010)
- World Health Organization (WHO). (2007). Maternal and Newborn Health/ Safe Motherhood, Division of Reproductive Health. *Care in Normal Birth: A Practical Guide*. Report of a technical working group. Geneva: WHO, 1997. Accessed January 6, 2009. Available at <http://www.who.int/reproductive-health>.

Childbirth Chat



When you call or email I will offer you more information about participation in this project.

[illegible]

APPENDIX B

PROFESSIONAL RECRUITMENT LETTER

ISU IRB # 1	09-485
EXEMPT DATE:	3 December 2010

Amanda Hardy
Iowa State University
1323 Palmer
Ames, IA 50011

Dear

I am writing to request your assistance with my dissertation research. I am a doctoral student at Iowa State University in the Human Development and Family Studies department. I am in the process of collecting data regarding women's experiences with pregnancy and childbirth as well as the early days of parenting. I would greatly like to discuss the relationship between medical professionals (obstetrician, nurses, lactation consultant, etc.) and women during their puerperal period. One aspect of my study is the social and historical context of childbearing and how these contexts may influence outcomes - specifically exploring fear. I am contacting you as a professional recognizing that you would have significant insights on this subject matter, and I hope to learn from your knowledge and experience.

If you choose to participate in this research it would require approximately 1 hour of your time on at least one occasion. A time and location would be arranged that is convenient for you and an interview would be conducted. I would record the interview on digital voice recorder, in order that I may transcribe the narrative data you provide. I would likely need to follow up with you to ask any clarifying questions at least one time, in a meeting lasting approximate 30 – 45 minutes. Again, the follow up meeting would be arranged at a time and location convenient for you. Communication can also occur via phone or email if this is necessary. Participation is voluntary and you can withdraw at any time; information you provide will also be kept confidential and anonymous.

If you are interested in participating in this research, please contact me at 515-231-1523 or ahardy@iastate.edu. I would be happy to provide you with more information that may help you determine if you would like to participate. I thank you very much for your time and hope to hear from you soon.

Sincerely,

Amanda Hardy, MA
Iowa State University
PhD Student
Human Development and Family Studies

APPENDIX C

RESEARCH SUMMARY SHEET

Research Summary

Research Project: The United State of Birth: A Feminist Critique
Amanda (Mandi) Hardy, M.A., CD(DONA)

Background Information:

In American society, there are a number of ways to conceive a child and there may be just as many methods of actually giving birth to the child. Vaginal unmedicated birth, often called “natural” childbirth, is no longer the norm. The use of medical interventions during childbirth including electronic fetal monitoring, anesthetics, episiotomies, induced labor, and elective caesarean deliveries have all been on the rise since the 1970’s¹. The historical and socio-political reasons for these changes are ever-present in today’s experiences, but do individuals recognize this influential role? Additionally, one might question if this normative way of giving birth in America has any impact outside of the delivery room.

Research has suggested that the use of interventions as well as complications during childbirth can influence both maternal and infant well-being – both psychologically and physically. Specifically, women who experience more medical interventions or complications during pregnancy and childbirth have higher rates of post-partum depression and post-traumatic stress disorder². Issues of women’s empowerment or personal self-doubt following childbirth might also be considered with examining the notion of well-being following childbirth. Does the woman feel empowered by her birth? Does the mother experience joy – joy in her role, joy in her relationship with her child and family³? A healthy maternal-child relationship in the first years of life (commonly referred to as the “critical period”) is an essential element to healthy child development⁴.

The influence of fear on childbirth outcomes has been studied and indicated as being a significant predictor for intervention use. The more anxious or fearful a woman was preceding her birth, the more likely she was to have multiple interventions and ultimately increased the rates of Cesarean delivery. Fear of vaginal delivery is now a medically billable condition for Cesarean and fear of childbirth in general has even claimed as a psychiatric diagnosis called tokophobia^{5,6}. Many of the studies that have explored childbirth fear have focused both on what women fear and also how fear affects the outcome of pregnancy, birth, and even early parenting; however, few have asked “why?”. Therefore, one of the primary purposes of this project is to explore what it is that makes women afraid of childbirth or rather “why are a women afraid or not?”

Guiding questions:

- What are the childbirth experiences of American woman?
- How do women make meaning of their childbirth experiences?
- How do women navigate and interpret the maternity care culture in the United States?
- What role does history, culture and social politics play in individual lived experiences?
- Are women fearful of childbirth, why or why not?
- Has there been a change in perceptions about childbirth over the past 30 years?

Purpose of the project:

It is my hope that gaining a better understanding of the experiences of women may aid in assisting other women in the future. It is my belief that both pregnancy and childbirth experiences can have an impact on early parenting, which ultimately influences child development. Improving pregnancy and birth for women has the potential to ripple far beyond the delivery room! Additionally, this particular project is my dissertation and its completion will contribute to the doctorate in Human Development and Family Studies I hope to achieve upon completion.

Participant Expectations:

Agreeing to participate in this project means that you are willing to share your story (your experiences) with me. I consider this a collaborative project with my participants; this work is in many ways as much yours as it is mine. I hope to collect data in the context of everyday life, meaning that conversations need not occur in a formal researcher-subject manner, although they can if you desire this format. I am willing to hear your stories via email, phone calls, or in person – in a one time telling or over several conversations (this depth is at your discretion). I hope to speak to women who have experienced childbirth in the past 30 years, as well as professionals (doctors, midwives, doulas, lactation consultants, etc.) who provide care and support to women during pregnancy, childbirth, and early parenting. I believe that any experience is relevant, and if you wish to share it I am willing to hear it; again, the choice is yours as to the depth of your participation. If you do wish to meet face to face, these meetings will typically last around 1 hour per meeting – scheduled at your convenience.

About the researcher:

My name is Amanda, but I typically refer to myself as Mandi. I have a masters degree in psychological counseling and worked as a mental health professional since 2005. I am married and in January of 2008 I gave birth to my first child, a little boy named Jack. He was born in a hospital with the assistance of a Certified Nurse Midwife (CNM). I completed training to become a certified birth doula, through DONA International, in September of 2008. I am in the process of becoming a certified childbirth educator (CCE) with the International Childbirth Educators Association (ICEA). In January 2009, I enrolled in Iowa State University (ISU) to seek a doctorate degree in Human Development and Family Studies. I teach an undergraduate course at ISU and also work as a research assistant. Although, studying childbirth is a topic for my dissertation, for me it is much more than this – I am truly passionate about supporting women (in various ways) during this time in their lives. My study and work in this area will last far beyond the completion of my dissertation!

References:

1. Tew, M. (1998). *Safer childbirth? A critical history of maternity care* (3rd Ed.). London, NY: Free Press.
2. Fisher, C., Hauck, Y., & Fenwick, J. (2006). How social context impacts on women's fears of childbirth: A western Australian example. *Social Science and Medicine*, 63, 64-75.
3. Axness, M. (2007). When the joy of the mother is missing: An organic perspective on postpartum depression. *Journal of Prenatal and Perinatal Psychology and Health*, 21(4), 315-319.
4. Barr, J. A. (2008). Postpartum depression, delayed maternal adaption, and mechanical infant caring: A phenomenological hermeneutic study. *International Journal of Nursing Studies*, 362-369.
5. Hofberg, K., & Ward, M. (2003). Fear of pregnancy and childbirth. *Postgraduate Medical Journal*, 79, 505-510.
6. Hofberg, K., Brockington, I. (2000). Tokophobia: An unreasoning dread of childbirth a series of 26 cases. *British Journal of Psychiatry*, 176, p. 83-85.

APPENDIX D INTERVIEW SUMMARY SHEET

Interview Summary Sheet

Participant Name: _____ Interview # _____

Interview Date: _____ Today's Date: _____

1. Briefly describe and/or reflect on the interview.

2. What were the main topics or issues that occurred during the interview?

3. Are there any additional questions you wish to ask in the next interview?

4. Describe the interview in three words.

5. Summarize the information/ideas regarding research questions:

Research Question	Information
What are the CB experiences?	
What did the experience mean for her?	
How was maternity care system understood and navigated?	
Role of historical, cultural and socio-politics?	
Experiences with fear	

6. Anything else that struck you as salient, interesting, important in this interview?

APPENDIX E

INTERVIEW QUESTIONS

Demographic Questions

- What is your year of birth?
- Child(ren) date(s) of birth.
- Highest level of education obtained?

Discussion Starters

- Tell me about your first pregnancy, as well as any different experiences in subsequent pregnancies.
 - Share whatever you believe is relevant to your experience
- How did you experience your pregnancy (emotionally and physically)?
- Did you experience any fear during your pregnancy or birth?
 - What were you afraid of?
 - How did you cope with these fears?
 - Where do you think these fears stemmed from?
 - If you were not fearful, why not – what made the difference?
 - If you were fearful, how would your experience. Have been different if you had not been afraid?
- What three words come to mind to describe your experience with pregnancy?
- What three words come to mind to describe childbirth
- What three words come to mind to describe parenting
- Tell me what you enjoyed about your pregnancy
- Tell me what you did not enjoy about your pregnancy
- How did you prepare for the birth of your child?
 - What type of birth were you planning (natural, surgical, use of medications)
 - Did anything “get in the way” of you achieving this type of birth? If so, what was it?
- Share your “birth story” with me - *from going into labor through the time when your child was actually born.*
- How did you experience your child’s birth (emotionally and physically)?
- What did you enjoy about childbirth?
- What did you not enjoy about childbirth?
- Did you have any professional support for childbirth
- What was it like for you to bring home your baby– to parent your newborn?
- Do you feel that your experience with pregnancy or childbirth influenced how you parented
- What do you wish you knew prior to pregnancy, birth, or parenting?
- What do you wish you had not known prior to pregnancy, birth, or parenting (i.e., things that “‘didn’t help’)?
- During your pregnancy and childbirth, do you believe that your care providers had your plans (hope and desires for your birth) in mind when discussing your care?
- Did you feel supported and included in decision-making during your pregnancy and childbirth?
- What “advice” did you hear about pregnancy, birth, and parenting?
- What were your experiences with birth growing up (i.e. birth of a sibling, etc.)
 - What did you already know or belief about birth from your upbringing?

Discussion Starters – Professional Providers

- How long have you been providing care to women?
- In what capacity do you provide care (i.e. what do you do?)
- How would you describe the experience of pregnancy and birth today vs. (date relevant to their years of service)
- How have women changed during this time?
- How has the type of care you offered changed?
 - What do you think has caused these changes?
 - Why do you think these changes might have occurred?
- What do you notice about fear during this time (i.e., have you noticed an increase or decrease)?
- Do you address women's fears as part of your work with women during this time?
- What are your goals for women's pregnancy and birth experiences?
- What are your thoughts about any connections between birth experiences and parenting?

APPENDIX F TRANSCRIPTION NOTES FORM

Pseudonym: _____ Date of transcription notes: _____

Codes:

CODE	TIME	CODE	TIME

Poignant Quotes:

QUOTE	TIME

Three words:

Interesting or significant notes from the interview:

Remaining questions:

APPENDIX G

EXAMPLE OF USE OF TRANSCRIPTION NOTES FORM

Transcription Notes

Pseudonym: Reid (Professional) Date of transcription notes: 2/21/11

Codes:

CODE	TIME	CODE	TIME
^{Worst} In charge / Control / Not Blame, ? (Baby genetics)	00:02:08	Business of Risk manage...	
Most important thing we do	00:02:09	Psych experiences	00:11:25
Lawyers / STRONG Incent.	00:02:27	Woman's job to protect child	00:13:30
Midwife control	00:02:51	Patient driven c-sect.	2 00:01:31
Getting sued	00:03:39	"Beat up"	2 00:03:28
Paid more for c-section	00:04:23	Worst case, scenario	2 00:03:15
Policy VBAC	00:05:13	Not that bad	↓
Risk (VBAC) 1 in 1000	00:05:36	Empowering women	2 00:03:40
Fear of Suits	00:06:30	Attractive Birth	
Birth Plans	00:07:50	Being a woman (blah)	00:04:00
Poignant Quotes:	2 00:06:19	Pathology Perception medicalization	2

* whose response

QUOTE	TIME
• They don't know who to trust, they don't know right away	1 00:52
• Not in charge of the wave, just ride the wave	1 00:04:23
• "Most important thing we do is tell people not to worry, and try not to get in the way"	0:02:28
• Women see a c-section way out of difficult pregnancy, lawyers agree." Strong Incentive, (Note Question)	
• "As long as you did a c-section" - discussing legal	00:04:39
• "get paid more for c-section, why in the world would we delivery somebody vaginally?"	00:05:13
• "You lash them down, you do it, and you apologize" (VBAC)	00:06:52
Three words:	
N/A	

Interesting or significant notes from the interview:

- * Refers to self as surgeon repeatedly
 - * Lawyers, malpractice, getting sued → frequent "theme"
 - * Why not doing VBAC's (what women believe is reason)
 - 00:09:56 00:07:25
 - ↳ 80 a year, economics
 - * Somewhat avoidant of psych issues → went to law (legal) 11:59
 - ↳ women will/want to sacrifice for their child?
 - ↳ message in office: "This isn't bad..." → Is this informed???
 - * How interview started ... he sits and begins speaking (he initiates)
- Remaining questions:
- Will he share his personal rate?

APPENDIX H EXCERPTS FROM TRANSCRIPTS

-Women-

Going into my pregnancy, I was fearful...I do have generalized anxiety disorder

Getting pregnant meant things I wasn't going to be in control of

I just built up the anxiety every time (appointments)...is it going to be okay?

I know what my bodies doing and how I'm feeling it should be okay

My body is going to know something isn't right. . . I just had to keep advocating

My pregnancy was good, I was healthy, but I didn't like it – medically, I was terrified, every visit I was thinking, what might come from this.

I would trust my body, but then there were so many appointments, just turned it all over and I guess the doctor is going to know best and I'm going to have to bite the bullet...

Husband came and laid down the law with the doctor...everything is fine with her outside the hospital

The [doctor]'s very medical, and I understand she has to look out for herself...don't want a lawsuit, I get that, but at the same time if they know me as a person – not just medically – if you know me psychologically, spiritually, if you get the whole me you're going to understand that this isn't an issue, or at least you're going to understand that when I'm advocating and saying this is okay.

I want another baby, but my anxiety level based on 1st pregnancy has me wondering how many more tests. What are you [doctor] thinking? What's going to be written about my on my chart that I don't know about, that's when I'm admitting...why is this and that happening...why am I not allowed to...I'd like to be more involved

Not every pregnancy is the same

There's definitely a fear factor, my anxiety is just whoa!

I could use the information a little less...sometimes I just don't need to know this much, made me anxious

What about your emotions?: I was excited, but afraid to show because of medical aspect always hovering about that, because I don't know how this is all going to end...fears about me, not baby

Am I going to be able to care for baby?

Mental Health Therapist: Really saw me as a person, not just, here's a lab sheet with medical numbers, it was here's Isabella.

Nobody's a fan of being in the hospital. . . so let's make this as pleasant as possible

You'll know your body

Network of friends...I can do this, I can get through...

Oh that wasn't so bad, I could do this again

Doctor 'oh, your placenta is really healthy,' I'm too tired to argue at this point...didn't you hear me

I felt great, but I would never take that because I was always thinking what are the doctors thinking, what else haven't they told me?

Not a fan of doctors, hate being in hospital, at the end of the day still peace-of-mind, still security of knowing I'm in good hands. They've been through enough training

We're going to make this the best possible experience

Glad I was at the hospital, safe place for me to be...a little less of the medical would have been nice though....attacked, bombarded with when checked in...that scared me. Didn't know what was happening...'well, your chart says'...

He says you need to have this and he's the doctor

He's the doctor, he knows, well I don't know this doctor from any other, so why would I feel comfortable with what you are saying, but okay I guess I have no choice. Then I was scared.

Pregnancy: my body wasn't mine, it was babies

Just embrace it. Always kept in mind, but as I neared that appointment I was like, crap! I don't know what doctors thinking, I don't know what test she's doing to want to do next...Panic attack, wondering what's next

I knew my body could do it, but they kept pushing...tests...well my bodies telling me too, and if we could work together on that...I'll take a back seat and let you do whatever you want to do

I really wanted to labor down and they were totally fine with that, which I was really surprised.

Then 2 hours late they were like 'well we need to help you out somehow' that's when they decided forceps

Did have an epidural at 8cms

Amazing what your body does when relaxed does some pretty amazing things

If going to prevent c-section get on that

I could feel tugging, like baby wasn't engaged...felt pulling a lot...could feel internal pop of pressure...weird feeling

I didn't feel baby, I couldn't feel coming out...felt delivery of placenta and thought it was cool, wondered if this was what it would have felt like to feel [baby] come out

Just a swoosh

Part of me mourned at that moment, because it was like, oh he's not in my anymore...yah know, and that's kind of sad

Nurses were phenomenal...'really it's not a big deal,' why can't the doctors just say that

Felt the nurses were more advocates for me then the doctors

Midwives: so laid back, more person-to-person experience than doctor-patient experience, which I appreciated. I had slightly elevated BP [MW appointments] neither of them worried, they didn't make a big deal about it. So that was one experience. The midwives were kind of like, 'whatever' doctor was like, 'well let's do a little more.' So is that difference between midwives and doctors or just my experience

When I saw the midwives I had to explain that my BP was going to be up a little higher and they were like, 'it's okay, don't worry about it Jody.' Really, okay! I'll just take a seat and relax. I felt much happier versus oh I got through that appointment now to the next

What is CB going to be like?: it's going to hurt. Gonna hurt, hurt, hurt. Really built up that it was going to hurt and be bad.

Where do you think this impression came from?: Media

Knew it would hurt, knew you go to the doctor

Doctor said we can go in and induce

Asked for some kind of pain meds. As soon as I could have them, I'm sure natural is wonderful and all...

I don't know if I really had a plan

I don't see a need to put myself through that pain, if it hurts, then I'll get medicine so it will hurt less

Physically I was fine. Emotionally I was rocky

"We'll do this first and then this" (doctor)

After 11 hours I wasn't progressing the doctor said we could do a c-section...let's go get her, why hurt if I didn't have to

So we had a c-section and they went in and got [baby]

I could feel tugging at me, then baby came out and they showed her to me and then they took her away and closed me up. That was the gist of it.

2nd birth VBAC offered as option: but the idea of pushing baby out of me really felt very scary

I knew it must not be that bad, but still scared me

If I had another baby now, I would have another c-section, because I'm still afraid of pushing a baby out, just so scary and traumatic to me

It just seems more organized and controlled to have a cesarean

Either is a fine option, I'd rather go with a plan...systematic

[baby] was fine. Small, 5 pounds. Stomach fine.

2nd baby if breastfeed because I refused to pay for formula and I did not qualify for WIC. 1st baby was formula-fed because I had WIC and it did not even occur to me to breastfeed her

How do you think your pregnancy and birth influenced you and your child? I don't know. I don't feel like that, not a real mom because I didn't push them out.

When mother's are telling their war stories, yah know about 'I had to get 37 stitches' yah know all the bragging about...the birth experience, I'm like I just showed up and an hour later they got her out. So I can't relate to those stories

Were you afraid? Yes, defiantly, about getting baby out and how much it would hurt. You see stuff on TV about how much it hurts and how bad it's going to be and screaming and all that. I mean I felt, it must not be that bad, but...

Did fear influence you? Yes, I think so, when they gave me an option and said I didn't have to do that [push] I was like okay. Fine, I can say I tried, you can go in and get her and she'll be just fine. 2nd time around I thought that worked fine the 1st time, let's do that again. Still being afraid of pushing the baby out

Why were you afraid? Where did fear come from? Logical part, hole this big, head this big knowing there is going to be some stretching and all of that. Seeing childbirth on TV, yelling and screaming and cussing out partners. I don't know that I'd heard many stories of birth at that time except for like very long labors

What's the climate of the culture? Go to the doctors at first, and have all prenatal care. Also have to go to the class, the prenatal class to be sure you know what's going to happen and then you plan, pack your bag. Have everything planned out.

My boyfriend was like women have been having babies for centuries, he was like you don't have to learn how to have a baby. He didn't think I needed to go to a class to learn to have a baby. I wanted to know what was going to happen to me, wanted to know what to expect and what was normal.

Do you think your cesarean was necessary? No. my doctor was in and out all day. And I think, just as much as, if not more than I was, can we just get this done with. Doctor said we can let you go longer and see how things go, or we can go ahead and get [baby] out now. So I was thinking thins might be fine, but I don't have to wait if I don't want to.

Do you feel cheated out of experience? No, I wasn't excited about the experience. So...I wasn't looking forward to that. Don't have any bad feelings about it. She was fine. I was fine. And I didn't have to push and I have this pretty little baby girl. Everything was okay.

Who wants to run that risk

Do you feel you made the decision? [doctor] told me what to do and I did it. It was really just, okay this is what you do, I'll do it, without even a whole lot of thought even.

The 1st time it was just a matter of he's the doctor he tells you what's supposed to happen and what you're supposed to do and you did it. Not even a question of, do I get to decide. He's the one who is the doctor he knows what he's doing

By any means necessary to make it happen, so let's not ask questions about the rest of the process

At the time I was just not very thoughtful about the process. I was just like it is what it is

None of this I ever even thought about. It's just like I had my baby. This is how she got her. Okay.

What do you think would have help decrease your fear? Being able to have a real conversations with other people. Not just other people, but real people who have been through it and hearing the okay really I know it hurts, but you didn't wish you were dead. I went to class to know what to expect, but they go over clinical things you know, the medical. Having somebody along the way to say...it's okay. Someone I love and trust say that. And not have the doctor be my only source of information.

The norm is: you go to the hospital, you have a doctor, and you get your epidural, yeah that's the norm

The complete opposite of natural is regular, and natural is an alternative and really hippie-dippie. They look at your like you're crazy for doing that

Well for me, that's you choices, go for it, I'm behind you, but then I need you to not judge me that I chose to do something different

C-sections are for celebrities who were too vain to have babies. That's what people think about women having c-sections

It's your choice

I imagine it's more money for the hospital...they stay longer, there are other people like the anesthesiologist...it's a business too

If you are responsible you'll have all these tests

When the baby was born, they took her away... and then I was all alone, like what about me. I was alone with all these people, they all know each other and I don't know any of them

I thought it was a dumb policy, they wanted me to do something I had just done three months before and it hadn't changed.

I decided to look for other options, wasn't seeking home birth

Hospital make me really anxious, so a homebirth just made sense

Did some research

Other than a c-section, there's not much [midwife] can't do

She's highly experienced

Pregnancy was uneventful

Labor was not easy, it was really intense, painful, hard, somehow I got through it, I just remember it really hurt

My labor had stalled. But [midwife] was willing to let me take as much time as I needed

He wasn't coming out, and she asked if I wanted episiotomy. I asked if it would hurt...one more push and his head was out

Traumatic birth. Took a long time to think about having another after that

Used a support belt to belly bind, acupuncture, chiropractic – discouraged, nothing seemed to work

I was desperate. It was a deadline that was stressing me out, really didn't want an induction in the hospital

Panic attack during labor, everything stopped....afraid of the pain

Vocalizing a lot

I could tell I was hitting transition

I can't do this, I can't make it through, it was really intense

Midwife checked me and just said, 'your complete,' didn't tell me a measurement so I wouldn't have any discouragement. Got in the pool after that and contractions were less painful. Oh then I can totally do this

Could feel baby move down

Oh my God, I need to get her out now, I couldn't hold it, couldn't stop it

She was born in the water, she weighed 9pounds and 5 ounces

Pretty uneventful

Public response to HB: never had a negative reaction to it. Amazing how people assume no prenatal care and no one attending. No care, people think that about homebirth.

Birth certificate: Feel like homebirth records are not as valid and hospital records

Misconceptions about HB: 3 sets of people – 1. Oh that's amazing, 2. Oh you're crazy, 3. Oh that's great, but I could never do that (you're really brave, I'm too high risk).

[Midwife] takes high risk and makes them low risk through proper care, she believes most high risk actually aren't

Changes between your two births: I did notice with my second one going post-dates women in our generation were, 'when's the induction' and older women were, 'oh yeah, no problem'

Going into labor is mental

Climate of culture, what is the message: went over (post) with both pregnancies with 1st I was never asked about induction date. With the 2nd I got to the point I didn't want to deal with people...they would just talk about induction

My husband and I come from this evolutionary perspective and I don't want to mess with this cycle that we are evolved to have

It's a cherished thing to be a parent, I don't know if I would have felt that way having not had the struggle [with infertility]

It was really helpful to be friends with others who have kids the same age

Seeking infertility support: went there because we liked their protocol

Treated me not like, I'm the PCOS....

I'm not manufactured for infertility, but found it's working

I was reserved about sharing, like is it real?

I was always waiting for the next appointment. Yah know, every time I got to go in, knowing everything was okay

Yah know, they have a standard battery of tests and I was okay with doing them, it felt planfull for me to know. After one of the initial screens...'there's a chance your baby had downs'...of course I go right to work case scenario...tears...they give this spiel that this test that we do can give a lot of false positives. Test was absolutely wrong

I wanted to know the sex of the baby, helped me to feel an emotional connection...there was a dialogue there

Group therapy with other women

Towards the end I started having [complications] difficulty, but overall it was comfortable and I enjoyed it (speaking of pregnancy)

I went in for an appointment, feeling fine, they took my BP, and they were like 'lay down.' The doctor was concerned so they put me in a wheelchair, wheeled me across the street to the hospital and admitted me right then (she was diagnosed with pre-eclampsia). I was told, 'we're going to observe you'

They let me go home the next day, but put me on bed rest

I had to find a place to not stress...just doing what the doctor says and it will be fine

They only let me stay home

[doctor] said 'I'm not happy with where you are at with BP,' so I was back in the hospital. Everything was looking better then overnight things changed

I was told 'we are going to induce you because we feel it's in your best interest, for your health'

So they moved me from this one little room to a delivery room

Before they started I asked if I could take a shower, I just wanted to feel like I was clean before the whole thing started. Yah know, I shaved my legs...how silly is that

So, I felt good before it all [labor induction] started

For the induction they did cervadil

[the doctor] was going to require the epidural...didn't want my BP to spike during labor because of stress

During my pregnancy I devoured books...I did take the classes because I really wanted that information...I really like the babycenter.com email that came every week

I was a little afraid to think about the birth, how bad it's going to be

My mom said, 'don't trust what you see on TV, it's so dramatic, not real, it's not that bad' from her experience...there was this movie that came out while I was pregnant, they show

birth at the end of it...it was so horrible, I had to shut it off (Knocked Up)...yah know, you get those stupid images in your head.

You know you're a little worried, but I wasn't going to freak myself out about it

Knowing I'm kind of a wossey person...I'd want the epidural

After 12 hours doctor checked me and said, 'okay your're looking good, I don't think we are going to do anything else at this point, just keep checking you'

I told [doctor] I was in pain and I couldn't get comfy, and [doctor] decided now is time for the epidural...then I just checked out, they'd wake me every half hour to roll me over

I was still kind of out of it, I didn't feel really a pressure, I just felt a little funky...they lift up the blanket and [baby] is being born, her head was coming out...the shock on my husbands face was unbelievable...she was just coming...when the doctor came in she was shocked to know she'd missed the entire birth...she just came out on her own. The nurse dropped the bed really quick, put my feet in stirrups, threw the back and caught [baby] just in time

[baby] just made her debut, she wasn't going to wait for anything

Doctor only walked in to do aftercare

[baby] just delivered herself to the nurse, right there

I was so relaxed, my body did it without my thinking...I tend to over analyze things

There was a relief of knowing I was going to have to have the epidural...I was planning it anyway...no fear and stress...thinking about how baby is it going to hurt

They wanted to get something in [baby] right away, don't know what, but they gave her formula with iron right away

Throughout the whole day we had been being warned about baby born at 4 weeks early – then she was this perfectly healthy little girl...just so grateful...so many things could have been...and here's this perfectly healthy little girl.

Tell me about the emotions: from one being to two, so strange

With infertility there are always jokes about is she mine (was it my husbands sperm), so I had a lot going through my mind

Yah know, when I was holding her for the first time I was still kind of in a fog...of course, I'm thrilled, kissing her, checking her out...

Some people say that joy an bonding isn't right away...I can't say it was instant with me

[My husband and I] chose to be by ourselves through the birthing process

When we came home...I just bawled...yah know at 36 weeks ready, but wasn't. There must have just been this weight that I was carrying, once in confines of own my own house I could let it out...release tears, that everything was okay

Please everybody with my choices

Major stress of desperately wanting to breastfeed, and it not working...it was just never meant to be, for me that was the hardest thing to let go. I think for me it was admitting failure in some way...it was something I always wanted to do...I felt I was being deprived...spent a lot of time crying about that...it was an overwhelming thing

[breastfeeding was] the biggest stress, everybody does it, no big deal...for me it was awful, because I couldn't...I did everything the nurses said...such an emotional thing for me to let go of...to be okay with

I had a premie that was not to be taken in public for any reason other than doctors appointment

Looking back I could have been a little depressed...I told my mom I felt like I was in a fog...not being allowed to leave the house except for doctors appointment was very hard.

Guilt and beating myself up over being a working mom...no [day care] provider is going to be you...let that go, she's okay, I'm okay...constant battle

The day care prefers a parent that is very business-like [for dropping off time]

My parenting philosophy, I think was just shut my own life down, I am mommy to her, yah know and it's two years later and I'm really re-evaluating where I am

Pre-perceptions about birth: worried, not having been through it...my mom's voice in the back of my head – 'don't believe TV, what you have seen is probably not accurate for what you are going to experience' her births were all positive

So I had these two images – mom and TV horror stories

And you know it plants that seed in your head

I never had to think about choices or anything, it was just 'this is how it's going to be'

Climate of culture: very medicine focused, because my body is shutting down. Putting all my faith in the doctor. Making all the decisions for me. Ultimately had to put all my trust in [doctor] in advising us, what was best decision for both of us.

I put a lot of faith and trust in [doctors] I just never explored any other options...I had no reason not to trust [the doctors] and it all worked out

Very heavily doctor and medicine-based (birth in 2007)...schedule my c-section, it's the convenient way to have a baby

Did you ever have any desire to have an unmedicated birth? Don't have a high pain tolerance, I've broken bones in the past and I tend to be whimpy. I know myself and I don't think I can get past that pain

I never thought about options to do differently. I guess I just thought this is how you do it...my mom had all her babies in the hospital with doctors, so I just never thought there was any other way.

My mom was working so hard to convince me this was okay

Discussing experiences when talking to other women about her birth experiences: totally write me off...totally feel invalidated because I didn't have long pushing or pain...yah know it's 'you got lucky,'...kind of hurtful...people won't believe it

What if women said 'how fortunate you are and wow what a great story...': Oh God, I've never heard that

It kind of makes me wonder if you even have to push, because I didn't...there's what you seen on the TV with all this screaming and pushing...do we need to push?

[On TV] you also see the baby crying and screaming and she didn't

I was always told I had these great wide childbearing hips, so sometimes, because of that I'd think maybe it's not going to be baby

I never felt fear because I put my trust in the doctor, that she's making the right decision

Never went to panic...had trust in myself and the doctors that everything would be okay – I don't know why I was like that.

Not having her own mother at the birth: her worry would make me worry

Breastfeeding: something that should be so natural...nurses told me, 'yah know she's a premie and you're big breasted'

Looking back I can have a different perspective I had a health baby, but that's what really sad for me [not being able to breastfeed].

Beat myself up – what's wrong with my body (not getting pregnant)

I'm not going to freak out or stress out about it

I more lacked confidence in parenting that pregnancy and birth

Once I've been through something, seen what it is, then I'm fine

What's at the other end of confidence for you? Just doubt

I have friends that have opted for c-sections after having to have one when labor failed, then the 2nd time they did [c-section] again because they didn't want to labor AND have a c-section anyway

The friends who have scheduled c-sections are so excited to get to pick the birthday

I wanted to try natural childbirth, but then all my friends and my hair dresser and everyone I talked to was all like, 'oh why go through all that if you get an epidural, technology's progressed, the baby's fine, why do this, it's not worth it' and so...

They broke my water accidentally at 37.5 weeks...then with my second one things went as they should have or whatever

I didn't want to tell anyone other than "Sarah" that I didn't have an epidural, because they think that you think you're being all high and mighty...I'm not trying to say I'm better than anyone...but too many people are like, 'oh you're crazy' or 'oh you think you're better than me, because you...' it has nothing to do with that

Pervious experiences with birth: I have cousins that I was old enough to remember when they were born, but of course, I wasn't there. My mom is a feminist, but she was also very big about breastfeeding and back at that time in the 1970s that was kind of looked down on. My mom was very big on...financially, partially, but she also just felt like it was the right thing to do...she was very open to wanting us to know she was doing this

My mom was very, 'you can do it natural...you should you should' my sister had an epidural and she said she wouldn't do it any other way

Especially when it comes to the whole picking to do a c-section...especially when it might not be necessary...seems like they are being selfish – I know that makes me sound so judgmental...that's just my observation. I don't mean to be judgmental; it's just kind of one of those observations.

Telling a story about friend: The first one she had to go through labor and then have a c-section...she was like, 'if you have to experience one, you shouldn't have to experience the other'

When labor starts on it's own it helps prepare the baby, whether it goes through the birth canal or not

Common statement you heard: I don't know how much of birth they had experienced or... everyone was just like, 'why go through all that when you can just get an epidural it's safe for baby it's safe for you, why don't you just do that'

My thoughts on it were yah probably I don't know, yah know, I don't know how painful it is so I should just experience it and then decide

Made your birth plan and all that, I'm open to it, but I'm not saying give it to me now

Discussing 'accidental' breaking of waters: I had been told the week before that my uterus was high and [she, other doctor] could not find it, because she was trying to check me or whatever and she was just feeling around and couldn't find it...and I was leaving and there was a gush...I needed to change me pants they were wet.

Called my sister to ask how she knew her water broke...so I guess it was a trickle for me

I thought I still had 3 weeks, so I wasn't ready anyway

My water may have broke, but I don't really know

Called my husband and he was like, 'oh you're probably just being paranoid'

Called doctor and they said it doesn't sound like your waters broke, but come on in, because we need to check you

They didn't tell me, and then I asked, 'well did she break my water' and [doctor] said, 'well there's no way you can prove that,' so they instantly covered their butts. And I'm like I'm not trying to accuse anyone. As long as my baby's safe and I'm safe I don't care. So then they went and put me on Pitocin...

(9am appointment until back in at 4pm) It was 12 hours by the time they did Pitocin, so they admitted me and then started it...because I was running out of time...they kept telling me

They didn't even give me the option, they just said, we're putting you on Pitocin

I had heard the whole, once your water breaks, you only have 12 hours, I hadn't heard that from my doctors necessarily, but from friends before I even went in...so yeah, I had that in my mind before I even was in the hospital

I probably was a little bit panicked, but I was mostly trying to prepare myself for the arrival for my child. I think if my husband hadn't been there with me, I would have been more panicky. ..we'd just finished our CB classes just 2 or 3 weeks before so I felt like I knew what I was supposed to do. I was pretty comfortable with my nurse and then they changed shifts and I was a little bit...ugh...then once I got used to the new nurse I was better.

My older sister didn't really like the birth process....so I had this little paranoia

The nurse told me, it's normal, it's fine, just keep doing what you need to do

For my second we lived here, but we kept driving to DSM because we were happy with the nursing staff and all. I have one friend that had a baby here in Ames, like 10 years ago and it was a bad experience, so they kind of convinced me to go to DSM...then I didn't have to get to know a new doctor.

I think having a good nurse can help a lot, I don't know if I would have had the birth that I had with my second if it hadn't been for the nurse. She told me, she asked me, if I wanted an epidural or not....she said you're doing so good, I really think you can do it and that's what I needed. . .if my husband would have told me that same thing, I don't know if it would have meant the same.

That rapport, that mental, yah know it's them providing better care

Contrast between two birth experiences: I was feeling a lot of pressure, but I didn't know that was a contraction. I thought what a contraction was, was a Pitocin contraction and with the second I was like whoa, this isn't that bad. Also with my water in tact, some people say contractions are a little less intense when your waters are intact.

The doctor came in and broke my water to move things alone

With my first one, I think I did need the epidural, because my body didn't have any time to transition...it was just like ka-pow, with the second it was more gradual.

The hardest part was the stitches after, and they handed me my son and I wanted to be enjoying that moment, but I had the local [anesthetic], but I could feel them...I wanted to enjoy that moment, but I wanted to just hand him to my husband because I was in a lot of pain.

What about recovery, did you feel different in that regard: With my second I was very anxious to get back home, my sons are only 21 months apart, and I'd never left my 1st son before

I wanted to go home too; I wanted to be there, I missed [other son] so much, I wanted to be with him. So in the morning I asked if I could be discharged and they said, 'you need to be here 24 hours,' and my OB was like, 'you're crazy' and I said, well I have another child and I want to be with him too and OB said, 'that's all the more reason you need to be here' and I was offended by that...give me a hard time because I'm too attached to my kids...so many of my friends say you need to loosen the raises and live your life. And well, they're part of my life and I want to live it with them.

You know I've always kind of thought that's weird [having a lot of people there] and I think society kind of says that too, but it really might be support.

Because [NICU] nurses took him first and then they handed him to me

That nurse, she was so supportive

[Husband] can be reassured by somebody that's not family, talking about a doula

My nurse was telling me, look, look, you can see his head

I told my husband I didn't want anybody at our house when I came home – I wanted it to be just us, those moments to be the three of us

Bringing him home from the hospital was this monumental thing [for my husband] he was ours now

[Meeting a woman that had a natural birth] That was the first thing, that really put that seed in my head that people really did natural childbirth, because everybody else had just been telling me, 'get the epidural' and I didn't really think people did it anymore [have natural childbirth], so "Sarah" kind of put that in my head and then my nurse said, 'I did it' I wonder if I hadn't met her if I would have just gotten the epidural, because that's what I thought you were supposed to do. You know, meeting her, and hearing her story was like, oh it is okay to do that.

Talking about fear messages coming from women who have not even had babies: well yah, it's what you see on TV and in the movies

My mom had more of the, 'you're a strong independent women, you can do it [natural birth]'

For my mom it's not just that it's a natural thing, it's a personal strength thing.

That's one of the reasons I always said I was open to an epidural because I didn't want people to think I was all high and mighty, I really didn't want that

I think I'm going to say thank you to my friend "Sarah," because I don't know if it would have gone that way without her – and I think I need to tell her that, it's important

The OB that ended up delivering my second son was kind of pro-epidural, and so I thought about it, but the nurse....well yah know I want to make everything easy for everyone else...but the nurse telling me it was okay to do it without

[OB] said you're a less likely to have a tear if you have an epi because then you don't go to fast, if you go natural sometimes your body has a tendency to let you go to fast and you tear, I don't know if that's true or whatever.

I was paranoid about making too much noise with my second son because I didn't have the epidural...and my nurse kept telling me it's okay, and after I was like, I'm so sorry, and she said that was nothing, you did great.

Preparation: took childbirth prep class, breastfeeding class, and child-care class...I read the, what's the one that everybody reads, yeah what to expect when you're expecting. I've heard some friends say that they didn't read it because they think it scares you, but I didn't feel that way about it, I liked it.

His pregnancy was pretty textbook ended up having gestational diabetes with him which was the only kind of blip but I managed it really easily

wasn't a big deal and we kind of went into his birth just being like we're pros at this, this is awesome

they did a late ultrasound because of the gestational diabetes and they were concerned that the placenta was aging

So they induced me and I begged and cried and pleaded that I didn't want to be induced and she gave me another like 2 or 3 days as a bonus and then if I didn't go then I was scheduled to be induced.

when I was induced, I just really didn't want that because I wanted to be able to do a drug free delivery and I was just afraid of what pitocin would do and the possibility that I wouldn't be able...

insurance

now we've got all sorts of choices but at the time it wasn't an option. Which is what I totally would have chosen but I didn't want to foot the bill.

She would not strip the membranes, she was concerned about introducing infection or something like that. She said that she did not do that, but what she did offer was to break my water and see if that would kick it in because I was already dilated and effaced.

it was going no where

then it was kind of decided that I would do pitocin

I was having a really hard time managing the pain because I couldn't move around because I had to be on the monitor because of the stupid pitocin.

I'm a mover when I'm in pain so to not be able to move was really, I was really struggling on pitocin, by the end it was nearly back to back with hardly any breaks. And I wasn't progressing

But she then says while I'm being examined uh oh and that's the last thing you want to hear and she described it, she never used the word prolapsed cord but she described it that he had the cord in his hand and was pushing it forward and so it was an immediate do not cross go, do not collect \$200, we went straight into the OR, there was no discussion really. And there was really no discussion, it was just this is what we need to do and then he was delivered

it was just this whirlwind and then he was born and he had a double 9 apgar and he was perfectly colored and it was about a week after she was born where I started questioning what happened.

I began to wonder almost immediately if it was perhaps a convenience issue

protocol for a prolapsed cord is that the person that finds it stays there with their hand on the cord so that they can make sure that it doesn't move or get pinched and if that person hops up on the gurney and rides with you and stays there. Not only did that not happen but they took the monitor off of me completely

and it just seemed fishy and when I described to my mother in law what Dr. Bannet as him pushing the cord up she said that is something that they would have been able to determine much earlier on. Because it's not like I hadn't been checked before then, I had been checked all day

5 checks since

I became very skeptical and I think the first thing I asked Dr. Bannet while I was still in the hospital was can I VBAC?

I was that serious, and [my husband] like ok we've got this brand new baby, we are brand new parents and you are asking her what

shut it down

I asked her about it and she said Ames has shut [VBAC] down.

She told me that they are required to have an anesthesiologist, this isn't her words, these are mine, basically sitting in a waiting room flipping through back issues of Highlights waiting just in case and that the anesthesiologists weren't willing to do that.

Ames isn't willing to pay.

said yes you are a good candidate for a VBAC

I want a provider that will do a VBAC or would be willing to, if I can.

better vibe from once place and so that's where I ended up

one thing that people told me make sure it's not just you primary doctor that is okay to do that but everybody in the practice because depending on who is on call if you get someone who is like nope then you are stuck.

I was considered high risk because of the VBAC

found interesting was even though, they had it on their brochures and everything that they were willing to do VBACs it was a constant every visit, from like 10 weeks on every visit are you sure this is what you want to do, we have to reiterate the risks

he also knew that it was so sincerely important to me and when I broke it down I said Dave the risk is actually do we have another baby and that wasn't a question

go for the least invasive with the least complications on the back end so it was really important to me so he was absolutely supportive of that and I made sure that I said I understand that there could be medical reasons specific to me why it can't happen but that's what I want to be listening to. If there is something specific to me and this pregnancy, you are the doctor you went to medical school tell me about this, but if you are just talking about the general, I understand that, I appreciate that and I understand that you are scared because we are such a litigious society that you are scared that someone is going to come sue you and that's not where I'm at.

I feel like they were (risks overemphasized), I didn't care, I had done my reading, I knew how I felt and at that point I started looking at it as they have to do this because they are

covering their butts and sadly so much of the medical community is now driven by liability and covering their butts but I just kinda went alright you have to do this

let it go in one ear out the other

Dave I made the conscious choice to not have him come to appointments because I knew it would psych him out and I didn't want him to have it get in his head so he didn't come and it worked out fine because

it's frustrating that I just felt like everybody was trying to talk me out of it the whole time and if I hadn't been so, I wonder if I hadn't been so gung ho it would have been probably pretty easy

I felt like I had failed in his birth that I hadn't been an informed advocate as much that I hadn't asked the right questions and I hadn't pushed hard enough and I felt it was so important to me to have a vaginal deliver and there was a part of me that felt like I had failed in having a cesarean. Which is part of why it would have been so importing to do it right the second time.

As a woman my body was designed to be able to do that and I didn't have that chance, well I guess I sort of was laboring for awhile but I didn't get really the chance to do that and I felt that there was this fundamental, like that's a piece of being a woman. And I'm not saying that if someone does have children or if they don't have a vaginal birth that they are not a woman but for me it was a big piece of that. I wanted that sisterhood, I wanted that experience.

It was crushing because he was, it was presented as a prolapsed cord they had a neonatologist there and I didn't even see him, I heard him cry and I saw one pink arm flailing and they took him away.

watching someone else's baby be born. Then I was just out of it and then once I was in the recovery room then that's when they brought him

they didn't prompt that at all [breastfeed]

I asked right away if I could do that

that feeling of this is my baby is it? That disconnect.

Having experienced it both ways there wasn't, with him there just wasn't that euphoric moment of oh my good God I did that and that's my baby because I was such a passive participant

I was vomiting all over the place.

I can feel the pulling and it was very discombobulated

I had this vision of my natural birth and it couldn't have been more polar opposite

I even feel guilty looking back on it because I just love her birth experience so much and I just, his I'm just like eh and I feel like that was taken away from me.

I feel a loss for that moment with him that I had with her.

pictures

this first like look of amazement with her and there is goop and blood and sweat and it's ugly but its beautiful. It's just so different [with 1st]. I mean I'm smiling in both of them but it's a very different.

I ended up being induced

I'm like ok this is one of those medical issues, specific to me

they would not offer me the option of just breaking my water

and I was

they said no we don't do that, no you can't do that. So your option is, we are going to tap into you the minute you come it. And the pitocin,

I was hooked up

it was here is your IV here is your

I'm back at the same point where I was with him and I thought prolapsed cord aside maybe my body can't do this. I can't do this, other women can, but I can't.

one positive thing

your section

I had been feeling really positive, like I can do this, it wasn't a me issue it was a him issue. So I had mentally prepared for that but then when I stalled again I just, mentally I couldn't take it

if given the chance to ease into it I would do better

stuck at 4 and it just got in my head and I couldn't

Dave suggested well let's try some pain medication

Like it was as though my body had just been overloaded and as soon as I was able to turn that off and listen then I was like I'm pushing right now is that okay because it's coming

I remember asking for permission

I still look at the medical establishment as an authority figure as opposed to a partner so like I asked for permission to nurse him and I asked for permission to push her out, my body knew that I needed to do those things but I was still asking. So I remember asking for permission to push and is it okay I think I need to push.

I didn't really think that it was real, like I thought that it wasn't real and then our nurse was really good, she really listened to me

her whole shift

nice to have that continuity.

whoever delivers the baby is just roll the dice and who's on call

I had been building up to her birth since the minute he was born and so I was like you know what I don't want to miss this, I want to see this, I want to watch myself do this

All of a sudden I was having a baby and it was just the most amazing, and the very first thing I said after she was born, said to Dave, I'm not done, I want to do this again. Like it was this euphoric and I've explained it to him since then, he does triathlons and its this you push your body to physically do something and you know your body can do it but there is still this doubt and that's what that was for me. It was my triathlon.

rippled through that part of my tackling my weight loss is actually linked to being able to do that. To see what my body can do and be interested and excited about pushing my body to do other things like he is like I think the VBAC was absolutely part of that

the most amazing, fulfilling

I don't feel like I was bullied into any of it, possibly the induction

if I can do it again I'm hoping that I do go into labor on my own

apparently my body just likes to hang onto these babies

they tell you these stats like well the second baby is always bigger as though it's gospel and I can absolutely that is common but it's not a guarantee.

I said ok I'm not a doctor and I know I'm a sample of one but my second was smaller, it does happen. Don't let that be a reason [to not VBAC].

I would like to avoid pitocin at all costs

I don't know how much control I have if I have a situation where I am overdue

if it's a situation that is specific to me and this pregnancy I will listen to that and I will do that. And part of the reason why its so easy to just go with the cesarean is it's not like we are talking about a situation with my foot, where I'm the only one who pays the price if I choose to wait for surgery and this is so, you've got all these issues of being a good parent tied up in it and so you feel like if you make the wrong decision I'm hurting my baby. I will take all kinds of risks for myself but I don't want to risk my baby.

when push came to shove I wanted the VBAC more than that [talking about pain meds.]

if I can use [meds] to help get me calm that's only going to make it easier to accomplish that goal which is more important. It was worth it, I was able to be up and walking around that evening.

the doctor that started me had to go to her kids' conference and she tagged out and another woman came in and actually delivered

caught her

gotten so selfish that I was like these people don't even matter. This is all about me so they can do whatever they want, I'm having this baby.

I earned this baby!

I really didn't want anyone else in the delivery room and I wasn't every opposed to a dula but I also never was willing to take the initiative to find one

if he had been less supportive of my desire to VBAC but ultimately he was very supportive of it

so important to be an informed consumer. They have made being born a business and a product and as such you have to be informed just like you would when you are buying a car. It's your responsibility

once I started questioning the reasons for his cesarean delivery and when, at the very least it was executed poorly, at the worst it was completely unnecessary and it was because they were bored of me having been in labor for so long and not making any progress. And I wish that I had been more vocal and asked more questions and been more forceful and I think that is just so important that we are so ingrained that you have to be a good patient, well my definition of good patient is different now.

I need those people that went to med school that have the expertise, I recognize that I need help but it's help not decision making.

I feel so guilty about him because I didn't make the decision

I was in the driver's seat and with him I was so much more passive and I think that's what I learned and it's such a more fulfilling experience to have been more active.

The assumption that I'm stupid as the woman

live in a country where medical care is relatively accessible

I feel like there is that assumption and I also think that we have kind of been conditioned

we don't want there to be any risk, we think that we can have our cake and eat it too and that it should be this totally benign and sterile event and it's not, it's hard and there is always going to be risk.

clearly that risk is worth the reward, it wasn't even a question

yeah there are some risks but there are risks to everything and you know there are risks to vaginal delivery without the VBAC

so she is an OB nurse, I think she does lean more toward being in favor of less interventions and she was very supportive of my desire to VBAC and I remember her saying that Obs largely they became Obs because they wanted to be surgeons and like where I sit as little miss 20-something going to have a baby I, it never occurred to me that that is what they, that's what they are focused and so it shouldn't come to surprise them that their natural instinct is to cut, you hear about that just buried between medical and surgical all the time that a surgeon's answer is always going to be to cut and the medical side is always going to be to treat and so if you are talking about an OB being more on the surgical side of things then that is going to be their answer and it's faster and they get to go home.

you don't become a garbage man if you can't handle working with garbage

Didn't know if they were going to put me on bed rest

Had an epidural, don't know what time

Pushing for 2.5 hours, wasn't progressing. They recommended cesarean. At that point – whatever it takes.

Under general for cesarean which was very frustrating.

It was fine (cesarean), worth it, whatever method necessary.

Pushing on back, legs up.

Worst part was that I was completely under when I had him. Didn't get that moment to first see him, that moment that you'll have forever. Seeing him for the first time 2.5 hours.

Wasn't an emergency, but I feel it was necessary, I wasn't making any progress.

I was open to pain medications, if necessary. I had the epidural and it was amazing when it did work. They don't know why it stopped working.

I know that it's going to happen not the way you expect it to happen. It out of your control here.

Like to know what to expect (personality trait).

Outcome was so worth it

I was a breech, and was born by cesarean, it was kind of foreshadowing for my own experience.

I wasn't concerned or worried about a cesarean, I knew the baby was going to come out how is best.

Some people love being pregnant, I just didn't love it. I mean, I'd do it again in a hard beat, but I hope that doesn't make me a bad person for saying that.

Should I feel guilt for cesarean? I don't feel guilty, should I?

That's how it needed to happen. Everybody's healthy, that's the ultimate goal so it's all okay.

Really disappointing thing about not being conscious. Painful for me and my husband. He couldn't be in the room either, because I was under general anesthesia. There were more risks, I guess, because I was under general.

My husband was torn because he also couldn't share that moment with me. He had to choose between being with me or going with our son after he was born and taken out.

When I first saw my son 2.5 hours later they brought him into my room and he had this little yellow hat on. I joked to my husband, it's a surprise that I could joke about it at that time, I said 'oh did he come out that way?'

Best moment of my life seeing him, it was just love, don't know where that comes from.

Obviously concerned about his health and he was fine, he was born healthy. You find out your pregnant and that's the first thing you think about is, is everything going to be okay? Is everybody going to be healthy?

That's what matters. That he was healthy.

Obsessed with the photos my husband took in the nursery when the nurses were cleaning him up, because that's the part I didn't get to witness, I didn't get to be a part of those first minutes of his life and I totally missed it. I'm not blaming . . .

My mom was supportive, prepping me for whatever. Cesarean almost seemed like foreshadowing.

Moral support from family (verbal) and friends.

One friend was always telling me negative trauma stories. I didn't want to hear those stories.

It was a great day, it didn't go as expected, but it was a great day.

Would have been beneficial to hear about actual reality of birth – not just “oh it's a great day”

To know that people go through it and do it again was one thing I thought about

Probably would have a cesarean again, I don't want to go to Des Moines, I know that's a silly reason, but VBAC isn't an option here.

From my husband I need to have his support and approval – well, not approval, but...

Baby stayed in the nursery at the hospital and was brought in every 2-3 hours to breastfeed

Am I doing something wrong? (breastfeeding)

What birth meant to you: “it was like I officially grew up. I was not as selfish anymore.”

Birth was not the best

Not many people that I would tell that I didn't enjoy pregnancy

Some anxiety about having another

Did not feel defeated because I was okay and prepared for a cesarean

Does how we are born matter?: No, as mother it shaped my views. I was a cesarean, and I turned out okay.

People are so judgmental...do you hear that....she's a bad mom...worse label you could have (why we don't talk about our feelings / experiences).

I wish I had seen what was going on, I worry about having to go under again

Is it any of your business why I had a cesarean? Should it matter, baby is healthy.

Not allowed to have mixed emotions, if you're upset it's because you don't love your child.

Pregnancy was uneventful

I'm in mid-30s, expected to take awhile [getting pregnant], that's what everybody says.

In my past I've been very crunchy granola, and I knew I wanted un-medicated birth.

Pregnancy not an illness, wanted someone to assist me in having a baby

My body, I'm in charge, you need to tell me, then I'll decide – norm is this doesn't happen.

Nervous, but fear is not the right word. Is baby going to be okay, normal things, am I going to be able to do it?

Want to be in control (personality)

Bystander to own experience – I had friends who had a lot of things seem to just happen to them

I want to be the one who is making decisions

Hard-core hippie crunchy self

It's a slippery slope I think, if you give in to one thing others follow

MW, she sat down and talked to me, told me before what she was going to do and then I got to decide.

Have you had standard tests? MW: I'll let you do what you want.

It was really, she put it back to us, for us to decide. She wasn't the one in charge, she was a conduit of information.

Got pregnancy rash (PUPP), excruciating. Around 32 weeks. I thought it was a heat rash. . . I had to decide between itching and vanity.

Due date came and went

I was on the online pregnancy forums – and have you had the cervical checks, membranes swept, all that.

My midwife asked if doing that stuff would psych me out and I said it would, so she said let's not do it then.

The system is set up that at this point this is just what you do

NST, the baby did not behave for the computers – I think that made the tech lady mad

I did not want induction

What can I say no to, what should I really do. I trusted this midwife.

My mom had flown in to help with the baby

Husband only wanted it to be me and him, so I was going to defer to him and what he wanted

I think I was starting to get resigned to the whole thing (not real contractions). I was cranky about it. Saw [induction] coming down the line. I didn't want to be unhappy about birth.

My water finally broke and I yelled downstairs that I either just peed all over everything or my water just broke and I think I didn't pee. Everyone was excited.

They'll either let you wait at home or have you come in. You don't have to come in just because they say – you can decide.

Gave us these forms for epidural, I said I don't want to do that. [Nurse] said that I should look at them anyway and I said no. Then she said she'd see me tomorrow morning to have that baby. I was like, what? And she said, 'oh yeah, you're not having that baby before tomorrow.' I was in good spirits, happy – I was just like fuck you. Not cool. Apparently, you can't be happy when you're in labor. Luckily then she left.

During breastfeeding class I was talking with one of the nurses and when she found out I had a birth plan, she wasn't happy. She said, 'don't mention that to anybody else.'

Really glad that we had wrote that plan. It was really good for my husband to think about and talk through all of that stuff. I had spent a lot more time thinking about it than he had.

I'm a control freak

Stupid gown – I was naked before too long.

The midwife was almost invisible, in a good way. She would come in, stand in the corner and watch, I was okay, so she'd then leave.

I put my foot down and said I want the tub...the mw said okay.

I was in the tub for awhile, it was wonderful.

My first cervical check ever I was at 10cm and MW was like 'oh you're done.' This was 1am and I had checked in at 8pm.

I tried a lot of different positions

Trouble finding the heartbeat, some concern about that. I don't remember any of this of course.

They put that electrode on her head, which really hurt. I was like, whatever, let's just get a baby.

I don't want to do this anymore, I'm done. I remember someone laughed at me saying that.

All of a sudden the MW said, 'reach down and pick up your baby.' And there she was eyes wide open and we were all goopy all together.

Then we had a baby at 2 in the morning

I do think that nurse came back in the morning and she didn't stay long (laughing). I and did it without the epidural too, so f you! (laughing).

Being in the hospital was an excuse to just focus on my daughter for those two days – nothing else.

-Professionals-

Fear and childbirth are linked, since the beginning...the fear we have now is an unnatural kind of fear"

Fear the lack of community they feel

I think women are insanely brave

Hold fear in their heart and don't talk to each other about it

Not fearing a bad outcome, as much as a fear of losing control. Having things done to me that I don't understand...fear of being a mom

The cost of the loss of community

Had she been in your inner circle [included in birth] had she held your hand and looked into your eyes and talked about it afterwards, what a difference that would have been

It takes a village...you don't know what that means until your pregnant. And all this take a village and we don't have a village anymore...women are feeling a need for this and it's not there.

If she's already feeling she gave up her power and her decision during pregnancy and childbirth...they did to her...she was delivered, she doesn't go to a hospital and deliver, she is delivered...disempowering self as mother, person, citizen

Birth is what it is. It is a transformational, yah know caterpillar to butterfly – metamorphosis to a whole other being – you can't help but be. How do you take that transformation...go inside, listen to intuition or follow a prescription

Have to have hospital privileges...scope of practice...so they really force you to...

Like being able to expose students to non medical model, yah know different philosophies . . . being a voice of feminist perspective, informed consent, empowerment. All those things our medical system is missing. . .

Psychological impact, life-long impact

Not consenting, is not consenting

How many of us are in control of anything once in labor?

No idea what impact the hospital, and being a patient and the labor and delivery nurse had on each and every single delivery she participates in

I thought I could make decisions for myself, I thought that I had control because I had a birth plan and because I was a labor and delivery nurse

I was labeled high risk because I wasn't getting consistent early prenatal care with them

They wanted to put me in the correct box...you are just one big liability...what kind of fucked up system are we in

Does this make any sense to you?

Goal of good outcomes for moms and babies

Take that power...change people's lives

Question yourself constantly, question others constantly, and listen for the answer, because it will come to you

Describing routine scheduled cesarean: “nobody ever told [baby] that anything was going to happen...there was no post-it note stuck to the womb saying today is the day”

Put [baby] in a box with beepers and buzzers and don’t let the parents touch [baby]

Unnatural and traumatic, we need to recognize this and do things differently

Ruff [baby] up

We are talking about this mom and this baby, not all moms and all babies. One mom and one baby at a time, that’s it

Everything went good, why do I not feel good?

Encourage dialogue about her perspective of experiences – what they say it is and feel

Interruption of bonding time

. . . important for all of us not to interpret somebody else’s experience they way that you would

Tell me about your birth in your own words...bring it to me raw...tell me what you feel today...this is a safe place and I’m a safe person

What does healthy mean? That means I’m here walking and talking...I think it’s more than that...the holistic person.

How is this experience going to affect them later in life?

Don’t feel can talk about [not feeling okay], cuz it’s what’s wrong with you. We as a society tends to put labels on this...instead of validating

What’s reflected in parent’s eye – from society

Stop bringing your own stuff in [to birth]

You know as a fucking practitioner sometimes I just need to be in bed before midnight. What’s messed up about system...so I have to sacrifice self. Yah know, when I’m been at a birth for 40 hours and I’m just beside myself with needs that have been unmet. This needs to not happen. We need to have a village, a community of safety and a recognition where everybody is on board with things like informed consent, empowerment...

We need a community, then we all can take care of each other

When they transfer, we can’t hand them over, so we stay...

Innate in us [women] to be there for each other

With today's drama...TV shows

It did not happen because it was easy, just a fluke, just happened...pushed aside

It would be easier if we had an open society. Our society is so Backwards and closed and inhibited

Politically, emotionally charged thing like birth

What impacts a woman's birth more than how she feels about herself, her partner, and her baby? Her mind is going to be the biggest thing, the biggest thing when it comes to, translates to, how she's going to give birth

The normalcy of [birth]

You're fine, everybody goes through that. You're fine. Just because everybody goes through doesn't mean I'm fine or okay. . . It is a big deal

That's all that matters. No it's not. How do you define health, how do you define okay...and how are you to define for me or anyone else, what matters

Can each and every person be empowered enough to define that for themselves. That was not all that mattered for me or...it was...so don't bring in all this feminist crap you want to heap upon me...

Each person empowered enough to define for themselves what matters, what doesn't matter. .
. what okay is

Powerful voice the babies have that we as a society have learned to ignore

Sharing about a neonatal resuscitation: The second we put that baby on that woman's chest...truly transformative...I don't know how to describe the difference between complete rag doll limp and completely relaxed...for the first time ever, melted and relaxed, and breathing, everything [baby] should be. Transformative for all to see... and then, oh it's okay here's my mom, not even my mom, here's my world. The two regulating and transforming each other. That's what it's all about and that's what other people miss and they don't even know it, they feel it because we have an innate feeling of this is what it's supposed to be, and when it's not. It's not.

All the things that women say, especially with post-partum depression...I don't feel connected, I don't feel like he's mine, I don't feel like I'm a mom...not having the emotions to go with it

You perceived differently. Doesn't mean I'm right and you are wrong. You are you and I am me. Why can't we use that language? It's what everybody needs and wants. Not right and wrong, just you me – here there.

Listening to you, validating you

Baby had a say in it, not all about me, about our journey together.

They don't know who to trust, they don't know the right answer

I'm not in charge of the wave, I just ride the wave

Most important thing we do is tell people not to worry, and try not to get in the way

Women see a cesarean as a way out of difficult pregnancy, lawyers agree...so that's a pretty strong incentive

As long as you did a c-section, you did everything

Get paid more for c-section, why in the world would we delivery somebody vaginally?

You lash them down, you do it, and you apologize (discussing VBAC)

There's a real fear of lawsuits

Damaged birth canal, as a result of her own genetics and what the baby has done, 30% require some repair

Why are women not VBAC'ing? "if you've enjoyed 18 hours of labor, 3 hours of pushing, and a c-section, would you like to try that again?"

Women are willing to allow us to beat them up, in order to bring the child...get the outcome. They're looking for , it becomes a sacrifice

So when you are talking about empowering women. This is how women are expressing the power relationship...hurt me [cesarean] save the child.

When you look at the natural side...that's attractive to some women, but what's more attractive to most is 'save my child'

What is making women focus on pathology? "Medicalization of a normal process"

90% [of births] are fine...of the remaining 10%, you can predict...of the remaining 1%...those come out of left field

We're doctors, we don't talk about or remember what went right, we talk about what went wrong. That's the language Medicalization brought. Then women hear it and talk to their friends, etc.

Birth plans: I know most of this stuff, you don't have to instruct me...I know how to deliver babies...you've read one book.

We have to think legally because the lawyers have made us

Here are my rules for a delivery, when you come in monitor for 20 mins., then it's negotiable. If you are not okay, or baby not okay you have no options. I'm going to do what you hired me to do, keep you safe and baby safe

Your patient is the mother, until the baby is alive

Most women come in with the desire of hurt me, save the baby

What's changed? Women operating on fear...we've changed to a team system...everybody has a voice

Doula is a hired bodyguard to protect the woman against the medical system. Some will get in the way of me providing good care...escorted out of hospital under security. You're not here to protect her, I'm here to protect her...husband there to protect her...great bring a doula, as long as they are not a cop in the room trying to protect the patient from me. My goal is to protect [her] too.

I have the benefit of being lazy when I let nature take its course...work harder for a c-section

We don't descend from a brave species, natural instinct to be terrified

Convince it's going to be okay, big goal of my job is to reduce fear

Midwives: they have more free-time. I've seen them get into trouble (1% of time)...good someone around...

When you use forceps, you're going to get vaginal lacerations

As far as holistic approach there is a bias in medicine that women who want holistic approach are more interested in themselves than their babies. A woman who is more interested in her baby than themselves would opt naturally for a c-section

Nothing intrinsically wrong with the birth experience

We're safety people, here to protect you and your baby...then you have to deal with my fear level to manage these pregnancies

I've seen doctors have a tennis game coming up, so they did a c-section

Legally I can keep my house and my horse, everything else is up for grabs...my kids can't go to college...

They had a bad baby

Sitting around in the doctors lounge, knowing I'm going to have to cut her.

I'm going to get a good baby out

I can no longer defend [in court] this monitor strip...always somebody that will testify against you

Do I want to drag my family through this [lawsuit] or do I want to do a c-section? It's not fair to her, but it's fair for the rest of system

Cut you open

Informed consent is easy, you can always get informed consent out of her. It's always present the baby. I talk people out of their body organs, trust me, I can talk you into a c-section. It's a done deal, no one is going to stand up again that kind of pressure. You can twist people's arms to get whatever you want

Can I live with myself committing an injustice to her and giving her a good baby versus...for not doing it and putting my wife through...I've got to see my wife every day. If this lady doesn't like my care she can go to someone else

I hate lawyers

Nobody likes to point the finger at a bad doctor...all it took was one babies brain to get rid of a bad doctor. This is why we need legal...checks and balances

We are law abiding people

After delivery I get to watch people fall in love

If they have a horrible experience, they are going to be terrified of sex. It's my job to protect sex for the couple...greatest danger of delivery (sex)...importance of husband and wife bond

Focus has gone from doctors to mother's to babies, it's a pendulum and right now it's swinging towards babies, focus should be on mother's and babies

60-80% of women get post-partum blues

Why are [women] feeling defeated? If you had a healthy baby and a healthy mom you won. This is a pass fail class. There are no medals being handed out for those who endured the most pain

When moms get together now and talk the whole emphasis is on your sacrifice for your child

We don't know what's best, sorry...let the mechanics play themselves out

Joke, the longer the birth plan the faster the c-section...its safety first

Homebirth: I don't support what you're doing, because legally...provide you with all the care I can to make that least likely to be a disaster

Medicalization is necessary

Amazed at how much fear drive every aspect of what I do

In America a chance to cut, is a chance to cure, you never get in trouble for being aggressive

We're all going in terrified [doctors and women]

C-sections on demand are going to increase...women don't want to stretch out their vagina and they want to avoid repair later

I knew in my soul things were supposed to be different

Back then there was absolutely no research – just did what nurses said

Nurses are not being trained in normal labor

[Nurses] not taught labor and delivery, taught management

We knew it wasn't right, we talked about it...

They would put me on a cart and take me to delivery

[Episiotomy?] Yes, of course

The mother has to meet what is normal for the mass number of women not what's normal for her anymore

Standard procedure, epidural, pitocin...

Birth rooms were a new concept when I was giving birth in 1983, but to use you had to be screened and low risk

Remember feeling shamed while being wheeled to delivery room pushing and knowing the people I worked with could see me

Required to attend hospital childbirth education class in order for the father to be able to attend the birth

Go to this one little room...it is assembly line

If you don't meet criteria we will intervene

They call it medical management, where the doctors take over and make sure you get delivered in the 12 hours

In the old days labor for 36 hours was fine. Now they want you to have that baby in 12. Is this evidence-based, absolutely not

Don't quote me, but I'll give you the picture of what's really going on out there [labor and delivery]

I think women are afraid of childbirth because of what they learned in sex education classes....teen pregnancies decreasing because they are so afraid and that fear is staying with them. Not shown birth in a positive way, because the powers that be did not want them to get pregnant. There's a benefit, teen pregnancy is down, but what risk – what horrible things have we done to get that?

My husband says I cannot talk about that

I haven't found anybody who disagrees with me – when men were OB's it was better

You can't talk about it, it's a hidden thing, the white elephant in the room...we older nurses know

It's top secret, it is so taboo, that we're gonna pretend that it doesn't exist

Female OB's will say, 'well I had [cesarean] and it was fine.' There's no evidence-base for that

Again, it's top secret, but that is what we talk about on the labor and delivery floor

Women OB's have less support at home...[she] comes to me and says we have to get her done. I don't have childcare tonight

Is that for mom or is that for the physician?

Women don't feel safe, they know they are on display (why women OB's have cesareans)

That's a huge secret on the OB unit

Just because the doctor is female, doesn't mean follows evidence-based practice. Same with midwives, just because she's a midwife, doesn't mean she follows midwifery model of care

But you can't talk about that

How are we going to address the problem if we aren't even going to recognize it

Everybody's forgotten the baby, what is best for baby? What's best for breastfeeding?

Abortion made the baby a choice, not a responsibility...took away responsibility

Now we've never know anything but...

A mother will parent the way she was treated during birth

I've seen this with younger nurses I work with, they do not bond with baby because they have to back at work in 6 weeks and 'I don't want to miss that baby when I go back'

It's the hormones that directly relate to how they are going to parent...if the hormone's aren't there you just watch

Why wouldn't you want your country to breastfeed and why would you not want them to normal birth? Because you want them back at work

"Well I'm not going to bond with the baby. I have to go back to work"

We can't say that. Breastfeeding is best, because then we are saying someone is being a bad mom

Look at what women are doing to women (cesareans / women ob's)

In the past we just had a different way of looking at things...people my age, we all agree on that

What needs to happen: We've got to have open dialogue...breastfeeding, hormones, the baby (what's best)

We can't look at individuals, every woman must fall into category...nurses don't have the skill set to treat individuals. Nurses intuition all gone now

Conveyer belt – no individual care

Changes: Choice has changed. Real issue is now moms don't have a choice. You cannot have a non-medicated birth because you don't have the nurses or doctors that have ever

seen...and don't know how to support it. Those days are long gone. You will not find nurses to know the words to use...the positions...the choice is no longer there for women. There is no choice. The nurse isn't going to be there at that moment to say you can do it. She's going to say, are you sure you don't want your epidural now? Because she's frightened of natural birth.

Doctors never follow a birth from the very beginning to the very end. Midwives will and your professional midwives do. OB's haven't seen the whole thing – never.

Choice issue tied to support

Since more medicalization, they don't know, they don't know normal birth

We can't talk about that either

Move from the farm – don't get to see how normal birth can be. People are not seeing normal birth.

Fear is promoted on TV

The father's pushing the epidural

Goal: to let there be dialogues, but I've been told over and over again, you keep your mouth shut. Don't you be talking about this.

This is what I am hearing, this is what other nurses are telling me. This is what is happening on the OB units, this is what nurses are saying

It's all about money, production, getting these women through, we need to know how to keep them on the line, we don't need them to know about normal birth...greed.

Lawyers are looking over the OB's shoulder

The rule is you follow the hospital policy over the individual

OB's can't even provide the kind of care they want to provide

I think we could prevent a lot of things if we could not induce before 40 weeks...that's the drum I would beat the loudest

Address the separation of babies and moms following birth....more interventions, more post-partum depression, and then a lack of bonding

To change things in the birth world, it has to come from policy.

I do have that hope

I thought how neat that I would be able to meet those women ahead of time and develop a rapport and know their family and then get to share in their birth experience.

don't have the ability to follow every person and so sometimes you are delivering someone that you have never met before and other times you saw someone the whole pregnancy and then you didn't get to deliver them. So that's hard but it's also the nature of the beast that we cannot do that, physically you can't follow everyone.

midwife philosophy

most physicians are trained in the medical idea, it just, that pregnancy is a disease and it's not a disease.

obstetrics is the study of the abnormal so if you are not sick then maybe someone who isn't so focused on the abnormal might be an okay

feel like you are sort of being pressured into incorporating all those

I haven't figured my own c-section rate for quite awhile but it's probably about 10.

high risk

looking toward the midwife and it made it hard for the physician to feel like they had that trust there.

hard to see women kind of just be led for them to not think what they would like or that kind of thing

and not just make all the decisions for them

who have said I want you to make the decisions for me, I don't want you to give me options but I think most people would like to be able to participate

Usually I will say this is what your options are and I'm not going to make the decision for you. You can ask me what I think, I will tell you that but in the end it is your decision. And if people have really strong feelings about anything, the people who really want to write a birth plan and really want certain things and I will say those things might happen and they might not, you can tell us what your preferences are but go into this with an open mind and we are going to do the best we can to have the birth that you want.

different group of women that do a home birth by choice but before it wasn't an option, that's what you did

it's not the same caliber of women that are doing homebirths that used to be doing homebirths.

whoever comforts you should be who is with you.

You definitely can see a difference in the women who have doulas or I don't have the opportunity because of my age now, I get tired but I did this past week act as a doula for a gal and either the nurse or I were with her constantly and to hear her say at 6cm I can't do this anymore when we first went into the room and she never said it again.

in your head

will suggest a doula to them

the younger nurses seem dependant on technology, they want everybody on a monitor, they want everybody epiduralized because it's something you can control. And you can go out of the room and know what happened while you were gone because she is still going to be in the same spot you left her.

they are afraid of it, they don't know what to watch for, they don't need somebody on the monitor all the time to know what the baby is doing, listen to the baby rate every half hour, you will know if something is up, you can just watch a women and know where she is dilatation wise if you have been with enough women.

They really don't know what to look for.

. I feel like they are worried what's going to happen next, what if, whatever. Well that's how birth is but there is more normal than there is abnormal.

to need to turn it around or we are not going to have very many vaginal births because when your c-section rate is 33-35% then those women are not going to v-back again so right now were are at 2/3 of our women are delivering vaginally and pretty soon it is going to be more than that probably because of medical malpractice

medical malpractice

well that isn't going to stand up in court

years have gone on, I hear that more with physicians they are put in that position where they feel like if they wait then that could be, and possibly have a bad outcome then you don't want to be sued, these huge malpractice claims.

children being taught that kind of where babies come from, how it all works and, that it's the norm

a c-section or maybe they had to have a general and they lose that first couple of hours. It's not like they can't get that time back, I think they can bond with their baby but it is a little harder.

grieving for a long time for having a c-section and she said it took her a long time, she had to grieve on her own, who do you tell that to? And who is going to feel sorry for you that you are having a problem because you had a healthy baby and you are fine, yeah okay. But some people need more than that, they need, I think most of us probably do.

were always removed from as a child

secret things that nobody ever really talks about

some people can't labor because they are so anxious about it, they never get in a labor pattern, they can't get them into a labor pattern, even with Pitocin or anything else, they just don't labor well. There has got to be something with the mind on that.

I've never had that experience where I have been able to talk to someone and then just all of a sudden they verbalize and then they labor, no I've never had that happen.

something else going on but it's not one of those things that is easy to do because people aren't, they aren't really in touch with their own emotions to know what is going on.

more experience with it when we were doing v-backs here

kind of like that oh the edge thing, once they were beyond it, it is like this is the new birth, before they were kind of in the old birth.

know she needed that and you could tell she would look directly into your eyes, she wanted you to tell her that she was doing alright, she would look from one person to the next and it's like we all agreed, oh she was doing great, okay then she could go on. But all it would have taken was for the nurse to be like the normal nurse go out to the desk, leave that couple in the room alone for the midwife to not be there or the physician not to be there and just to let them be on their own and she would have had an epidural when she was 6cm because that's when she thought she was losing it.

They need to be supportive of what they know that you want, if you want a natural birth, they can't be saying you know I think you should have an epidural, that kind of thing, it's not very helpful, in the end, it may make her more comfortable, but then it's going to make her sad in the end that that isn't what she wanted to do.

The epidural rate has gone **way** up from when I first started as a midwife, any woman had epidural but it wasn't like almost every single woman had an epidural. That's different. And

the expectation that you not have discomfort is there much more than it was, because their friends tell them, what's wrong with you? Why would you want to have a natural labor if you could have had no pain? And truly that's how a lot of the physicians see it. They don't see that there can be growth for that woman by experiencing her birth.

very important milestone in their life.

It's sort of like icing on the cake, it doesn't have to be there but when it's there is really nice to see that.

The women that sometimes work so hard and then that baby is laid on their chest or they reach down and pick up their baby and they are very emotional, it's just the end of a wonderful event. They get pushed as far as you can get pushed and look what happens in the end, you get this wonderful reward. It's visible in some people and in others I'm sure it's there, you just don't see it.

Probably in the 90s, I can go back further than that 80s when I worked as a labor nurse too, women were more interested in, women in general, like childbirth education and trying to find out what's going to happen, now I oftentimes will hear, I don't need to do that because I'm going to have an epidural, I don't need to learn anything, because I'm not going to need to know any of that.

It's a different philosophy?

I was trained as a labor and delivery nurse in a hospital

have idealized picture of what a home birth delivery would be and we know there are people out there doing unattended births.

I think that's too bad, there are a couple people who are doing home births that are qualified and I wish they could travel everywhere.

not even just about birth but about women's life in general that we be more supportive of each other.

I think in the US we aren't very good at that, in other countries, women wouldn't think of doing any large life event without their women friends that is such an important part of their life

don't allow ourselves to have those friendship and that support network that is better than any antidepressant or anything that is out there that someone can support you and get you through the tough times and you can do the same for them.

like I try and be their midwife but I'm also hopefully their friend.

I will just say well thank you for inviting me to the birthday party because they didn't have to ask me. I really felt honored. I always tell people, I would do this if I didn't get paid for it. It's much more than a job.

kind of thing and have it set up so we can do home visits afterwards and do that and I thought of doing centering, it works especially well with younger women, but you do, instead of having an office visit, we see each person individually, you have like a 9:00 slot and you have maybe 10 women who come and you purposely are dividing that up between those women who are experienced mothers and the younger women and people who have great supportive networks and people that are on the fringe.

if you are treated well in birth and someone mothers you then you will be a good mother to your child and I think that is very true and I think we are losing a lot of that when we talk about the medicalized birth experience.

just treating the superficial things

if we can't do that at the hospital

APPENDIX I CODEBOOK

Code	Description
Control	Whose is in charge here? Or What is in charge here (role of genetics and physiology, etc.)?
Responsibility / Blame	Insurance, policy, individuals (doctors, mothers, etc.)? Each interview seems to have some opinion/angle/view on this notion of blame or responsibility for birth and current climate in birth.
The most important thing	Safety? Health? Well-being? What's most important in birth? Can more than one thing be valued and achieved?
Incentive	Professional interview: What is the incentive to intervene or not intervene in birth (financially and legally).
Lawyers and Legal Matters	Professional interview: Fear of law suits, lawyers are driving up cesareans, what a lawsuit will cost (house and horse), <i>what suits have actually cost American birthing women</i> .
Midwife Managed Birth	This refers to the model of care in which midwives are the primary care providers for women in pregnancy and labor and obstetricians are only called in when there is a need to surgical intervention.
Getting Sued	Stories about lawsuits and how they have been a potential catalyst in changing the birth practices in America
Paid more for a cesarean	Doctors are paid more to perform cesareans than vaginal deliveries
VBAC Policy	Who makes and approves these policies, why do they / have they changed. What do women believe and report about their understanding of the policy.
VBAC Risk	As described and understood by the professionals, in practice, and as women report and understand these risks
Birth Plans	A document (legal?) that a woman may create before her birth indicating her desires during labor and delivery and her post-partum stay in a hospital.
Business of risk management	Obstetricians description of his "business"
Psychological / Emotional Experiences	How do women <i>feel</i> about their pregnancy and birth experiences? How are these feelings constructed and understood and what influences them?
The Woman's Job	What is the woman's job in respect to her child during childbirth This code stemmed from a professional interview, in which the professional described the woman feels her job (in life) is to protect her child at any cost.
Patient-Driven Cesarean Increase	Also, know as <i>cesarean on demand</i> . This refers to situations when women are requesting cesareans without medical indication.
"Beat Up"	This was a phrase used by a professional, when describing the

	notion that women are willing to be “beat up” themselves for the sake of the child’s safety.
Worst Case Scenario	The perspective of looking for the worst possible outcome to happen, then planning and preceding to prevention that outcome.
Not that bad	Expression used by a professional to describe cesarean birth and recovery.
Empowering Women	Experiences in which a woman feels strong, in control, and pleased with herself as a result of their experiences.
Attractive Birth	Birth Trends. What are women attracted to in birth, location, process, experiences, etc. How has this changed over time?
Being a Woman	Relationship between being a woman and birth process and experiences.
Pathology Perception	The medicalized lens, through which birth is often viewed in this country, which seeks out pathology even when none might exist.
Medicalization	Process by which a natural, biological or physiological process is brought into the medical sphere of management and control. The process is therefore, medicalized.
Choice	What are the choices that women (and professionals) are making regarding birth practices? (ex: VBAC, why / why not). Do obstetricians have a choice to perform fewer c-sections (legal implications)?
Childbirth Preparation	Birth classes or other ways (books, etc.) in which women prepare for their childbirth experiences.
The Rules	Obstetrician described his “rules” for delivery. What’s negotiable and what’s not. What do women know, understand, and how do they feel about these?
Patient	Who is the patient (mother / baby)? What are the experiences as a patient (rather than a woman / mother) – is this a welcome role, a new role, a comfortable role? Implications of assuming this role.
Hurt me, Save the Baby	An obstetrician described this as “most women’s desire.”
Training	Ways in which professional describe the influence of their training on their individual (and unique) approaches to childbirth. What are women’s understandings and feelings about the diversity of training and its influence on their birth experiences?
Safe Baby	Is a “safe baby” the primary focus of birth? What are the implications of this as primary focus? How did this become the primary focus?
Forcing	Is someone or something forcing up the rates of cesarean
1% Doctrine	This concept refers to a focus on the 1% of cases in which a negative outcome is unpredictable and unpreventable and how the focus / effort influences the other 99% of cases.

Holistic Approach	What is a holistic approach in medicine? Do women understand and desire this – do professionals?
Protector of Birth	Obstetrician frequently referred to himself (and his job) as the protector of birth, of women, of marriages (sex), and babies.
Waiting and Watching	How long should a doctor wait to perform a cesarean, what are the actual implications (legal, etc.)? How does a professional navigate this question and how do women feel about it on the other side?
Good Baby / Bad Baby	Obstetrician described how a couple had “a bad baby” or how [OB] was “going to get a good baby out”
Informed consent	The means by which a woman (patient) gives her consent to undergo a treatment or procedure. Legally a woman has to be informed, by the person(s) who will perform the tx or procedure, of the benefits and risks to the treatment or procedure before she consents.
“Cut you open”	One participants way to describe of a cesarean birth.
The Players	Who is involved in an individual woman’s birth experience? The hospital, the policy makers, the lobbyists, the doctors, the nurses, the spouse, etc.
Top Down	This was an expression used to describe where change needs to come from in order to change the maternity culture in America.
Tort Law	Liability suits.
Malpractice	A type of insurance that doctors must carry in order to practice medicine in the U.S. – rising costs of this type of insurance has often been blamed for driving various changes in maternity (and other) care.
Performance	How a professional (or a woman) goes about the process of birth (i.e. how are professional duties performed or how did the woman perform during birth).
Mechanical / Technological View	Describing the body (specifically the woman’s) as “machine-like,” references to the body that imply it is a mechanical object.
What’s Right	This code refers to how decisions are made and the “rightness” (perhaps from a legal standpoint) of decisions that are made during birth – both the woman’s and her providers.
Allow	LD nurse discussing historical and present trends, relating to what the hospital allows (i.e. “we didn’t allow father...”)
Evidence-Based	Refers the practices in LD and that are based on research evidence that the practice is beneficial.
Normal Labor	Labor that begins spontaneously, woman is free to move, no unnecessary interventions. . . spontaneous rupture of membranes... What is normal?
Best Kept Secrets	LD nurse repeatedly mentioned secrets of LD and the “things we don’t talk about”

Screened	Hospital policy that involved pre-approval for certain persons or procedures or occur or not occur (i.e. “had to be ‘screened’ before the hospital would allow...”)
Privileges	Who is given allowances, what are these allowances, and why?
APGAR	Babies are given an APGAR score at 1 minute and 5 minutes following birth. This score is used as a representation of the babies physical health.
They would...	Referencing hospital staff and/or doctors
That is a Lie	LD Nurse discussed information that was provided to women.
Sex Life	LD Nurse discussed the impact on sex life that an episiotomy can have. What references do other’s make to sex life and birth experiences?
Tied Down	Being physically restrained, by “monitors” or ? during labor and birth
Special Permission	Allowances and privileges that certain persons are granted/given
The Mother has to	What is required of the mother, who is requiring ... (rules?)
Personal Choice of Provider	Ability to choose a provider. Is there a choice for women?
Manufacturing / Processing	Procedures and practices in the hospital
We Will Intervene	LD Nurse discussing what happens when a woman does not follow “rules” during her birth
Medical Management	Philosophy that birth is something to be managed, and medical professionals are the ones who need to do this in order to ensure success.
Infertility	Inability to conceive a child.
Pushing Buttons	Being annoyed or frustrated by another person – element of intention?
Struggles	Difficult experiences and/or processes
“Not any one way is right”	There are multiple truths and realities
“Not as bad as...”	Comparisons
Stress	Mentions of anxiety, tension, a need to relax, etc. the role of stress in the process of birth and also the sources of.
Getting Pregnant	The beginning point of the maternity experience
Miscarriage	The loss of pregnancy
Protocol	A set of procedures that are followed and/or carried out in a specific prescribed manner.
Waiver	A legal document that when signed indicated that a person has been informed of all risks of a certain procedure, similar to a consent form.
Ultrasounds	Sonar imagining of a baby in the womb, medical experience.
“Over and Over Again”	Repetition of experiences, processes, feelings, etc.

Graduated	Moving from one level of care to another.
“Uneventful Pregnancy”	In the original context that this code first appeared the woman was referring to know “major” medical events occurring during her pregnancy.
Don’t Know if it’s Real	Discussing being pregnant after struggling with infertility
Natural Miscarriage	This refers to allowing the woman’s body to miscarry a baby versus undergoing a medical procedure (called a D&C) to remove a fetus, which has been determined as no longer viable.
Absolutely Exhausted	Description of one woman’s feelings about her first trimester of her pregnancy
“Had to do...”	In this context a woman describes the things she “had to do” in order to get pregnant following infertility. (power dynamics?)
Felt fine, never ill	Describing her pregnancy
Challenge	Describing experiences with infertility
Pre-Eclampsia	A pregnancy induced condition in which a woman has very high and unsafe blood pressure.
Relaxed	A feeling of little stress of worry, being at peace, comfortable, content, without fear
Testing = Planning	Does undergoing “routine” pregnancy testing equate to being a plan full person, and why (if at all) is this desirable?
Length of Labor	What is normal? Expected? How does medical management come into to play with this? What is evidence say?
Harmful to Many	Nurse referencing practices that were wildly used and harmful to many.
Meet Criteria	What are criteria, what does meeting them or not mean for women? Who sets them, why and how?
Top Secret	What information is revealed regarding maternity culture that participants feel should not be said, or is not said?
Taboo	Things that are understood, by a group of people, to not be spoken about.
Get Her Done	Referring to a woman’s labor needing to be complete and the baby delivered.
Is that for the mom or is that for the physician?	A question posed by a labor and delivery nurse
Safe	Feeling safe, being safe, who defines, how?
Male / Female Provider	Is the medical professional provider care and man or a woman and how do participants report this as desirable or influential?
Choice & Responsibility	What are choices, how does having them influence feelings and concept of responsibility (abortion example).
Bonding	Building blocks of relationship between mother and baby
Hormone’s	Role in birth. What is recognized about this role and what is the evidence for practices?
Breastfeeding	Mom feeding baby – what’s being promoted, how is birth influencing this. What do women desire, believe, feel about

	this?
Regret	What do women regret? Providers? Outcomes, why?
Waiting	When is it too long – how has the timeline changed over time? What is the outcome of changes?
Intuition	Behaviors based on internal feelings of appropriateness
Midwives	Care providers to women during their maternity tenure
Location	Being moved during birth, specialized care in specialized places – influence on birth (LD Nurse, story about cows)
Out-of-Control	What are women’s feelings and experiences with being out-of-control? (the myth of the “good patient”)
Rules	Hospital policy over individuals (LD nurse)
Separation	Historical impact of mother’s and babies being separated at birth
Elect	Undergoing a test or procedure during pregnancy or childbirth. The woman “elected” to have...
Planning	“I want to know,” “I’m a planner,” etc.
“We’re going to observe you”	Doctor informing a woman that she is going to be admitted to the hospital and is going to be “observed”
“They let me”	Referring to the things that her doctor allowed during pregnancy and childbirth
Waiting	Waiting for information, waiting for baby, waiting on...(the woman is waiting, who has the power?)
Moved	“then I was moved from one room to the other” (in order to have her labor induced
Uneventful	This phrase was often used to describe when labor was progressing without incident; however, it is the negative connotation that I note...implies events are expected (pathology).
Require	Procedure that a doctor stated the woman must have during her labor, in this case and epidural.
Media	Role this plays in perceptions about birth. Source of...(information or fear?)
Checked Out	How one mother described her emotions and behaviors following the administration of an epidural
“I had been being warned all day...”	A woman describes being told about the possible difficulties her premature baby might experience
“Please everybody with my choices”	Describing the task the woman feels she is facing, in her birth choices, but also parenting.
Let go of that	Desiring to breastfeed
“They’d roll me over”	Since having an epidural, the medical staff would come into the room every half hour and roll her over to ensure the medication was not pooling to one side.
Horror Stories	What is being depicted on television and told by other women and medical professional about birth

Medical Focus	Response given when asked to describe, “what the medical culture is at this time (2000s).”
Faith & Trust	Into...(doctors, hospital, nurses, husband, self, etc.)
Wimpey or Wossey	“I don’t have a high pain tolerance, I tend to be a wimp or a wossey”
Feeling Invalidated	Describing feelings when her birth experiences are not accepted by other women. They are “written off.”
Doubt vs. Confidence	Beating myself up, feeling prepared for the next time
Miscarriage	The loss of pregnancy
Midwives	Professionally trained care providers to women during their maternity period and childbirth
Nutrition Appointment	A medical appointment, required in Ames, in which a pregnant woman first meets with a nurse practitioner to discuss nutrition recommendations during pregnancy. Usually the “first” appointment at the clinic
You have to do it	Requirements, policy, procedures
“Dumb Policy”	One woman describing her feelings about a policy she is told she is required to follow
Irritating	People and or policies that one woman did not find pleasant
Look for other options	Finding other care providers. What prompts, where to look, what options.
Home Birth	A birth planned to take place in the home of the woman and assisted by a midwife
Struggle with decision	The emotional and intellectual process of drawing a conclusion about a way to proceed in a given situation
Time	Concept of time during labor, mentions of time (what context), how does time (or concept of time) influence the process. How long do procedures or necessary prep for procedures take, what are time expectations, etc.
Alleviate Concern	Reduction of stress or anxiety
Highly Experienced	What is knowledge and expectation of care providers
Research	Who has access, who undertakes research, what are considered reliable and accurate sources, etc. Role of this research concept in influence women’s decisions
Anemia	Condition in which the body does not clot, which can lead to significant blood loss.
Posterior	Baby’s positioning in the birth canal, this is not the optimal position for birth.
Non-Stress Test Biophysical Profile	Tests on the baby to determine how healthy the baby is, during pregnancy – often done when a pregnancy goes past 40 weeks.
Stalled Labor	When a woman is dilating and effacing and then ceases to do so for a significant amount of time during labor.
“Willing to let me...”	Describing the care provider’s willingness to allow....
Anxiety	Stress, fear, nerves.

Position for Pushing	Physical position of the body during the pushing phase of labor
Incentive	In the initial context a woman describes being offered and episiotomy as all the incentive she needed to push and deliver. What other “incentives” do women discuss or how are such “incentives” addressed in other stories?
Traumatic Birth	An experience which was physically and/or emotionally upsetting and difficult for mother or baby or both.
Stress	Influence of stress on pregnancy and labor
Planning	What plans are made, why, who is involved, and how do they influence pregnancy and birth experiences?
On Time	When a baby is expected to arrive or labor expected to begin according to the due date or estimated due date (EDD)
False Labor	Contractions that are not rhythmic or continuous, may last for days or weeks in irregular patterns. Typically dilation and effacement is occurring during “false labor”
Acupuncture	One women described seeing an acupuncturist once she went past her EDD as a means to promote labor to begin
Induction	An means of medical intervention intended to bring on labor
“I was desperate...”	Desire for an alternative outcome other than the one she believe she was facing
Panic Attack	Severe anxiety
Vocalizing	Used to describe the sounds a woman makes during labor
“I could tell...”	In this initial context used to describe a sense that the woman knew her body was at a certain phase of labor
Standard Procedure	Hospital or clinic policies or routines that are regulated to be performed or conducted on all women or babies, regardless
Irresponsible People	A woman who gave birth at home describes feeling that she often had to demonstrate that she and her husband were not “irresponsible people,” as the common assumption she felt she encounter was that they were
Misconceptions	Home birth mother describes the common misconception she faced during her pregnancy and birth. What do other women know and mention about this?
Illegal	What is legal in this country and state regarding birth practices and procedures and what do women know about this?
Risk Factors / Risk Out	In this initial context, refers to the woman who a homebirth midwife would refer to the hospital for their birth based on risk assessment
Post-Dates	A pregnancy that goes past 40 weeks
Mental Blocks	“going into labor is mental,” “mentally, I caused my labor to stall”
“I was young”	Reports of young age influencing perception, attitude, and approach to birth. Others who had these experiences?
Didn’t give it a lot of	Related to how a woman plans and prepares for birth?

thought	
Pregnancy Normal	Reporting an uncomplicated (medically) pregnancy
Emotionally Not Normal	Separation of physical and emotional experiences?
Big Knitting Needle	Description of the instrument used to rupture the bag of waters
Pain Meds.	Anesthetics
Pushing a baby out	One women reporting frequently about the “pushing a baby out” as a primary focus as she approached her birth.
C-Section = Organized and Controlled	One women described her feelings of a cesarean birth being a more organized and controlled birth option
Systematic	Other word used to describe a cesarean birth
Formula-Feeding	What influences the choice to breastfeed or formula feed. One woman indicated that she was eligible for WIC and provided with free formula, so she “never even thought about breastfeeding.” How do other women navigate this choice?
“Real Mom”	This quote was in the context of describing having a c-section versus a vaginal birth
War Stories, Bragging	One woman linked these two concepts. Do other’s report this, feel this?
Stereotypes	Minority participant indicated some concern and awareness of the stereotypes she felt / believed others were attributing to her during her pregnancy.
Told What To Do	One woman frequently cited this as a major part of her experience, “being told what to do”
Sources of Information	What are the sources women seek, find helpful, why/how do they find them
Having Real Convo.	One woman described what influence it might have had on her experiences had she been able to have what she described as a “real” conversation about what birth really is / could be.
Choice	What are women’s choices, how are they making them, how do they feel about them?
Alone	“They took the baby out and they took her away and then there I was all alone,” “They all know each other and I don’t know any of them”
Didn’t Progress	Labor that is not moving at a specific rate (dilation and effacement or contraction not occurring at predetermined rate of speed.
They	How one women referred to the medical professionals
“Closed me up”	Describing being stitched up after cesarean
Scary	What is cited as scary in birth
Go with a plan	Reason for having a cesarean for a second baby
Care Provider Patience	In this context the woman was speaking about a day care provider being patient with her child and her feeding patterns
Television	Portrays birth as screaming, yelling, cussing out the partner and ‘all that’

Logically	Small hole, big head... "I don't want to do that"
Stories	The way that women talk about birth ("war stories," "horrible")
Climate of Culture?	Medical
"get this done with"	Attitude about conclusion of her labor – cesarean (from dr. and woman)
Fine	"she was fine, I was fine" "I have this pretty little girl" "everything was okay"
Risk	"who wants to run that risk?"
The Good Patient	"[doctor] told me what to do and I did it, it was really just, okay this is what you do, I'll do it, without even a whole lot of thought even." "Not even a question of do I get to decide." "He's the one who is the doctor he know what he's doing"
Let's Not Ask Questions	"by any means necessary to make it happen, so let's not ask questions"
"It is what it is"	"At the time I was just not very thoughtful about the process. I was just like, it is what it is"
Childbirth Classes	"I went to class to know what to expect, but they only go over clinical things, yah know, the medical"
The Norm Is...	1. You go to the hospital 2. You have a doctor 3. And you get your epidural
More Money for Hospital	Performing cesareans. Business
Consequences	Of not giving that consent
Routine	Testing, procedures, etc.
Support	What are support needs and experiences?
Unnatural Fear	MW describes that she believes fear is linked with birth since the beginning of time, but now women have an "unnatural" fear of birth
Lack of Community	It takes a village and the village is missing
Birthing Hut	Describing birth in from long ago, women gathering together during CB
Universal Fears	Fears that most women have
Brave	Women are so much braver than they know or give themselves credit for
Holding Hands / Looking into Eyes	Support and comfort for each other during birth
Change	How have things changed?
Waterbirth babies	Babies that are born into waters
Routine Scheduled C-Section	Cesarean's that are planned before labor begins
Birth Circle	A support group intended to encourage sense of community and support. A safe place to discuss birth
Included	Brought into processes

Vulnerable	Mention of a woman's state during pregnancy and birth
Being Primal	Letting go of assumptions and giving into to natural instincts
Political	Birth is politically and emotionally charged
Nolmalcy	What is normal, how to maintain / improve?
Women Telling Stories	Discussing birth
Powerful Voice	MW describing babies as having a powerful voice
Transforming	Birth experiences
Hospital Privileges	Who is allowed to practice in a hospital and why?
Informed Consent	"not consenting, is not consenting"
Control	"I thought I could make decisions for myself, I thought that I had control because I was a L&D nurse, because I had a birth plan..."
"No Doc."	The label a woman is given by a hospital if she comes in in labor and has not been getting prenatal care, that they are aware of
Goal	"Good outcomes for moms and babies"
Question	"question yourself constantly, question others constantly, and listen for the answer, because it will come to you"
Birth Trauma	For baby, for mom?
Separation	Between mother and baby following birth
Attachment	How is this acknowledge and/or promoted by birth practices
Transition	From womb to world
"This mom and This baby"	"not all moms and not all babies" – individualized care
Perception	What does the women say and feel about her experiences
Use of language	Powerful influence, validation issues
Not to Interrupt for someone else	Caution of our lenses
Healthy	"walking and talking? More than that" "holistic person"
Society	"tend to put labels of things ...instead of validating"
Home before midnight	Practitioners needs going unmet as well, this needs to not happen.
Included	Feeling included in a decision
Trust	What does this mean and look like?
Building a Relationship	When, during 3 min. visits in office – reciprocity?
Innate	"it's innate in use [women] to what to be there for each other"
Drama	Television shows
Pushed Aside	When a woman shares an "easy" birth story
Open Society	Able to have honest conversations
Mind	"mind is the biggest thing, the biggest thing when it comes to ...translates to how she's going to give birth"
Empowered to Define	"Can each and every person be empowered enough to define for themselves...what mattered..."
Regulating &	Mother-Child relationship

Transforming	
We Know	Innate sense of knowing what it's all about
Journey Together	Mother and baby
Red Flag	high risk markers
Turned it all over	Choice, process, decision-making
Doctor knows best	Belief and trust in this notion
Enjoying what pregnancy means	Preoccupied with medical procedures (one woman described)
Laid down the law with doctor	Control issue? Who has it, why feeling this need?
Advocating	Need to do, how and why?
Person-to-Person Exp.	Woman feeling like she was talked to like a person and not a chart. Described a person-to-person experiences versus a patient-doctor experience
Not a big deal	One woman repeatedly used this phrase to describe her belief about pregnancy and birth, described like she was striving for it to be like that (not a big deal), but never felt she got that experience
Not every pregnancy the same	Women often describe this understanding or assumption, but rarely describe experiences that reflect this unique / individual aspect
Dissemination of Information	One woman felt that less would have been better, she felt information was often provided in a way that felt just enough to scare her, but not inform her
Argue	"I'm too tired to argue at this point"
Hear me	"didn't you hear me?"
Attacked / Bombarded	With medical when being checked in to hospital, "that scared me"
Panic Attack	Wondering what's next, what test are they going to do next
Trust	Knew my body could do it
Collaboration	Body is telling her....and if we could work together
Back Seat	"I'll take a back seat and let you do whatever you want to"
They Decided	"That's when they decided to use forceps"
Regret	"mentally, I'm done."
Amazing	"amazing what your body does when relaxed, does some pretty amazing things"
revent	"if going to prevent a cesarean, get on that"
Hurt	"It's going to hurt. Hurt. Hurt. Hurt."
Media	Where did concept that it was going to hurt and be bad come from?
Birth Plan	"felt good having...here is what we want...guidelines"

APPENDIX J

THIRTY-SEVEN INITIAL BROAD CATEGORIES

1. Pregnancy as pathology
2. Fears
3. Power, Choice, Control, and Informed Consent
4. Passive and Active Participation in Process
5. "I guess I have no choice. Then I was scared"
6. Informed Consent
7. Every pregnancy is different, but...
8. I'm a person, not a chart
9. It takes a village
10. Don't like hospitals
11. Induction
12. Real Conversations, Hearing 'it will be okay'
13. Stress & Relaxation
14. Do whatever you want to prevent a cesarean
15. Do whatever you want to save baby
16. Doctors and Nurses
17. Doctors and Midwives
18. Perceptions of childbirth
19. What the TV has told women
20. The Rules
21. Crazy & Other Judgments
22. Business
23. Health Reports
24. Power of Language – influence perception
25. The Birth Blame Game
26. Breastfeeding
27. Risk & Liability

Narrowed After Initial Development

1. Uneventful Pregnancy
2. Incentive
3. Planning / Preparation for Baby
4. How does woman feel about herself?
5. Didn't you hear me?
6. Vocalization, noise, and the notion of the good patient
7. Get the baby out
8. Questioning Self
9. Belief in body
10. Reasons for the use of Pain Medication

APPENDIX K

BRIEF DESCRIPTION OF EACH INITIAL CATEGORY

Pregnancy as pathology

Women often, nearly all at some point, stated that a pregnancy was “uneventful.” This seems to imply that, for whatever reason, women assume that some “event” (appearing to be medical) will occur. In this same notion one woman also said, “My pregnancy was pretty uneventful, so I guess I’m really lucky in that way.” The use of this phrase also speaks to the support that women seem to first describe, and therefore define, pregnancy by means of diagnosis or ailments they either did or did not experience. No women in this project simply stated pregnancy as “good,” but rather uneventful. The use of language certainly has implications.

Fears

“You know, if you are looking at fear in medicine that is the question and then it’s like whose fear do you want to talk about? Do you want to talk about the doctor’s fear, the patient’s fear, you know pick somebody, because we’re all going into this hysterical.”

Every interview confirmed that fear, at various levels and contexts, was present during their pregnancies and births. Different sources or types of fears were reported, from being in the hospital to pushing the baby out to not knowing. The professional participants also all noted their observation of fear involved in the experiences within the maternity culture. Professionals also cited their own fear of lawsuits as influential in how they carry out job duties and interact with women consumers (i.e. patients).

There’s definitely a fear factor, my anxiety is just whoa!

Power, Choice, Control, and Informed Consent

The frequent use of phrases like, “they said,” “they allowed,” “they did...” in women’s accounts of pregnancy and childbirth seems to have possible implications of control and therefore, ultimately the responsible for the processes. The use of these ‘power phrases’ seems intrinsically linked to control and choice issues, and therefore, informed consent. Women far less often used expressions like, “they asked me,” or “they offered me” and then described conversations that would indicate informed consent was given – no, women report “they gave,” “they went in,” “they had to.” Some interviews were specific in this regard to choice and informed consent and would simply indicate that they were not asked, they were told what to do and they did it – there was no choice or formal consent process. However, as one professional participant said, not consenting is, *not* consenting. These concepts also seem tied to the notion of being an active or passive participant in one’s own lived experiences (who is really in control here?). Furthermore, often when I asked women during our interviews if they knew why “they” had performed a specific procedure or intervened such a manner, few women were aware of the reasons. Many said, “I didn’t ask,” or

simply, “I don’t know.” From the perspective of the professionals who participated in this study similar and confirming concepts were echoed from their interviews as well.

Passive and Active Participation in Process

These concepts seem to go hand-in-hand with the notions of “who is in charge here?” that were discussed in the category of power, choice, control, and informed consent. When one does not have one of those (power, choice, etc.) or any of them how does this connect with their participation in the process. Some women seemed to indicate or imply being an active participant was either something they did not think about and plan for or perhaps even something they desired. It seems to be comparable to the notion of vacationing as part of a guided tour group or not – in the end both types of tourists experienced the same “scene,” just in different ways. The question that I then ask, given the nature of this inquiry (feminist), is regarding empowerment. Which experience makes the woman feel good, feel empowered? Ultimately only she can decide this, only she can say what that may be, but only if she truly has the option and choice to decide to be the type of participant she wants to be.

I’m like I just showed up and an hour later they got her out

At the time I was just not very thoughtful about the process. I was just like it is what it is

None of this I ever even thought about. It’s just like I had my baby. This is how she got her. Okay.

I decided to look for other options

If she’s already feeling she gave up her power and her decision during pregnancy and childbirth...they did to her...she was delivered, she doesn’t go to a hospital and deliver, she is delivered...disempowering self as mother, person, citizen

“I guess I have no choice. Then I was scared”

One participant’s statement, “He’s the doctor he knows...okay I guess I have no choice. Then I was scared,” seems to link the previous category (power, choice, control, and informed consent) with the impact on experiences. Lack of choice or lack of control has frequently been cited as influential in increasing fear – choice and control are undoubtedly psychological issues. Many women also remarked at how the very nature of pregnancy brings with it a feeling of one’s body not being her own. Other scholars use the word “vulnerable” to describe a woman’s physical and psychological state during pregnancy. The implication I’m trying to make here is that a woman, during this time of maternity, is already feeling a “natural” loss of control and vulnerability; therefore, making a connection between control, choice and fear should ultimately not be a great leap to make.

Informed Consent

Paige offered this challenge (adapted for this context) during our conversation about consent and choices: Think about it, right now, as you are reading this, think of a time you questioned your health care provider? Truly questioned them. Have you ever done this? How did it feel? Were you comfortable in this role (challenger / inquisitor), why or why not? Not simply in a pregnancy or childbirth context, but any context. When a doctor gives their recommendation (their expert opinion) what further questions do you have for them? Do you ask about alternatives, about risks of taking recommendation versus not taking it?

Judy made the following statement in regards to her birth, “by any means necessary to make it happen, so let’s not ask questions about the rest of the process.” These statements reiterate the notion or belief that we (Americans) should not question care providers. What Paige highlighted in this critical thinking challenge was the notion that, in her experiences, likely few people has ever (in contexts outside of childbirth) truly given informed consent. She address the idea that American society, our culture, has conditioned (socialized) us to behave in a certain submissive manner when interacting with medical professionals. This socialization is based on the notion of inherent power-dynamics – the person with the knowledge holds the power. This also points the concept of “the good patient,” and what women have experienced, and/or fear if they question their care provider. Several women in this study indicated a conscious awareness during the births, specifically, to behave as a good patient – meaning they intentionally suppressed their impulses³⁷(like vocalizing) to comply with the image of “good patient.”

Every pregnancy is different, but...

Both women participants and professional indicated a belief in the uniqueness of each woman, each pregnancy and each birth. Phrases like, “not every pregnancy is the same,” were common during interviews. However, contrastingly was also frequent reference to “standard protocols,” and “standard battery of tests” that each women, unique as she may be, was ultimately required to participate in. So which is it? Are women, their pregnancies, and their birth unique or “standard?” Jessica, a 30-year labor and delivery nurse and childbirth educator summarized this dichotomy simply by saying, “the mother has to meet what is normal for the mass number of women not what’s normal for her anymore.” Jessica went on and stated that, “[nurses] can’t look at individuals, every woman must fall into category...nurses don’t have the skill set to treat individuals,” and finally compared the maternity unit’s patient care procedure to that of a “conveyer belt – no individual care...it’s just keep ‘em moving. Get them in, get them out.”

I’m a person, not a chart

Speaking of individualized care... some of the women in this study more specifically addressed this notion and their feelings about being “a number,” “just a patient,” “a

³⁷Synonym: naturalness

chart,” or being referred to by a diagnosis instead of their name. Simply put, just because their care providers knew their name, didn’t mean the women were feeling like they were receiving individualized care. One woman stated, “the [doctor]’s very medical, and I understand [the doctor] has to look out for [him/herself]...they don’t want a lawsuit, I get that, but at the same time if they know me as a person – not just medically – if you know me psychologically, spiritually, if you get the whole me you’re going to understand that this isn’t an issue, or at least you’re going to understand [me].” Jody, who was seeing a mental health professional to address anxiety issues (prior to and during pregnancy) stated, [the therapist] really saw me as a person, not just, here’s a lab sheet with medical numbers, it was here’s Jody.” Finally, Heidi stated that she liked the facility her husband and her had selected for care because they, “treated me not like, I’m the PCOS.”³⁸

It takes a village

Paige spoke significantly during our conversation around the concept of needing a village to raise a child. In her perception, we not longer have a village (in concept or reality) in America. She spoke about the ultimate consequences of this, specifically, of course, to women during their birth experiences. How this village concept relates to support and nurturing and how this is necessary and needed in both birth and parenting. Several other women noted that having “other mom friends,” or “group therapy with other women” was beneficial to them as they approached their birth and parenting alike.

Don’t like hospitals

Several participants indicated a dislike or not being “a fan of being in the hospital.” Some indicated that being in the hospital or clinic setting alone increased their stress levels and anxiety. Other’s mentioned a desire to discharge as soon as possible to be back in their home where they felt more “comfortable.” One woman stated that when she got home from the hospital after the birth of her daughter she, “just bawled...there must have just been this weight that I was carrying, and once in confines of own my own house I could let it out.” This final statement struck me as particularly poignant and again potentially representative of the idea of the “good patient,” – a woman in *control* of her emotions, or at the least not expressing them publically. Additionally, this finally statement, speaks to the idea of emotional safety and security. She implies that her home was a space (her turf, if you will) in which she felt safe enough to express her emotions. With this brings in the idea that hospitals, perhaps by default, are less equipped to provide this emotional security.

Despite the fact that many women mentioned home as feeling better or more comfortable and a place of emotional safety it was the hospital that the women chose for their physical safety and the safety of the baby. “Not a fan of doctors, hate being in hospital, at the end of the day still peace-of-mind.” However, Eleanor also specifically indicated that the hospital made her nervous, and because of this, it

³⁸Poly Cystic Ovarian Syndrome

“made more sense” for her to have her baby at home. Eleanor also indicated more awareness or acknowledgement of the notion that psychological state-of-mind may significantly influences birth. Eleanor stated, “Going into labor is totally mental.”

Mind body connection: Panic attack during labor, everything stopped....afraid of the pain

Induction

Half of the women in this study experienced a labor induction, and of the half that did not each one made an unprompted mention of it during our conversations about their experiences. Reasons cited for induction varied from pre-eclampsia to unknown. The women whose labor began spontaneously mentioned an awareness about approaching “due dates,” and with that the impending possibility of being told they would “have to have” and induction or at the least a simple mention in the conversation about a hope and desire to “avoid an induction.” When asked about any culture changes that Eleanor might have noticed between the homebirth of her son in 2006, to the birth of her daughter in 2010 she indicated, “I Went over (past estimated due date) with both pregnancies and with the first, I was never asked about induction date. With the second I got to the point [that] I didn’t want to deal with people at all because they would just talk about induction.” Jessica, a nurse for over 30-years, also indicated that it has become, “standard procedure pitocin.”

Real Conversations, Hearing ‘it will be okay’

No participant indicated that she had a negative experience. Susan was the only women who gave any indication that she may have had some questions about her care, the procedures, and the motivations behind them when she stated, “I became very skeptical” – referring to the necessity of her cesarean birth. Regardless of the reports that experiences were positive, which was based – according to the women’s statement – on the fact that the baby was fine (healthy), I asked women what one thing may have enhanced their experiences even more and/or reduced their fears. Having more support was resoundingly the answer. Several woman spoke about having encouraging and positive conversations with other women prior to birth, and following, regarding parenting. One woman specifically referred to this as having “real” conversations, which seems to indicate a significant deficit – or at the least a feeling a lack of genuineness. Another discussed feeling a sense of comfort and encouragement that she felt from gathering with other women during her pregnancy in what she referred to as, “group therapy with other women.” Several women specifically stated that they simply needed to hear phrases like, “it will be okay” and “you can do this.”

Stress & Relaxation

In addition to mentions of fear and the influence this psychological construct has on the physical body, and hence childbirth, several woman made mention of “stress” and/or a need to “relax.” These statements were made in reference to pregnancy, childbirth, and parenting. The impact of stress on the body and on various

relationships (mother-child, doctor-patient, husband-wife, etc.) was noted frequently. Furthermore, several also noted a specific connection between relaxing and the progression of labor. “When I finally did [relax] my body was able to labor and progress...instantly.” Another woman mentioned a need to “get out of [her] head and let [her] body relax,” seeming to indicate an awareness of how her psychological state-of-being was influencing her physical bodily experiences – in this case, labor.

Do whatever you want to prevent a cesarean

All but one participant, Judy, indicated specifically a desire to avoid having a cesarean birth. Some of the comments women would make might indicate that they were comfortable allowing other interventions (pitocin, rupture of membranes, forceps) under the assumption these would prevent a cesarean. One woman stated, “if [forceps are] going to prevent c-section get on that.” I also find the use of the word “prevent” in this particular woman’s statement interesting. It’s almost as if avoiding a cesarean birth is as easy as preventing the spread of a common cold – if the correct measures are taken.

Do whatever you want to save baby

Beyond the interventions and treatment that women are willing to accept for the sake of avoiding or preventing a cesarean, ultimately what it appears to come down to is the baby. Dr. Reid, an obstetrician for nearly 20-years, indicated that, “women are willing to allow us to beat them up, in order to bring the child...get the outcome . . . it becomes a sacrifice.” He went on to state that, “hurt me, save the child” was the message he feels women are bringing to childbirth.

Most would agree this outcome of healthy baby is desirable, of course, for all. However, it might be necessary to consider one’s definition of healthy. Simply being alive – having breath and a heart-beat – is not the entire scope of health. Again, the notion here is that of a holistic picture of both mother and baby and when this broader concept of health is considered the entire experience and image of childbirth practice might be reframed.

Doctors and Nurses

There were often comparisons made between the type of care nurses were providing versus doctors. The women reported that nurses were often more encouraging, supportive, and simply “listened” more than their own doctors. There was often a statement, which indicated a woman wanted her doctor to say or do something the nurse had done. Such statements again seem to speak to power dynamics – although women appreciated, like, and even enjoyed what their nurses were saying and/or doing they still had a need or a sense that if not coming from the doctor it was not valid.

Felt the nurses were more advocates for me then the doctors

I can't imagine if I hadn't have had that nurse, she really made a huge difference for me

Why can't the doctor just say that?

In contrast, when speaking with Jessica, a labor and delivery nurse for over 30 years, she also makes note of this power differential. Jessica mentioned several times the things that nurses speak about and all agree are wrong – what they are seeing and experiencing on the L&D unit – but none of them mention it as it is not their place (either) to question the doctor. Dr. Reid might disagree with this as he stated that it is, “a team system...everybody has a voice,” and went to describe that in his experience the nurses he works with have “no problem” telling him how they feel about the job he's doing.

Doctors and Midwives

In addition to the differences that several women noted about nurses and doctors a few also had the experience of seeing doctors and midwives for their care and noted differences there as well. Of the midwives Jody stated, “[they are] so laid back, more person-to-person experience than doctor-patient experience, which I appreciated. I had slightly elevated BP [at MW appointments] neither of them worried (saw MW's on two different occasions), they didn't make a big deal about it. So that was one experience. The midwives were kind of like, ‘whatever’ doctor was like, ‘well let's do a little more.’ So is that difference between midwives and doctors or just my experience.” She also made mention of how the midwives called her by name and encourage her to relax. Dr. Reid also made mention of the difference between midwives and doctors indicating that, “midwives have more free-time.”

Perceptions of childbirth

Undoubtedly women reported that their believed childbirth was going to be painful and this caused fear. One woman said, “it's going to hurt. Gonna hurt, hurt, hurt.” Another stated that in her head she, “really built up that it was going to hurt and be bad.” Of what she knew about birth still another indicated she, ‘knew it would hurt, knew you go to the doctor.’ In contrast, many women also mention a belief in their bodies “natural” ability to give birth, because after all, “women have been doing it since the beginning of time.” What was interesting was that they cited their ability to endure the inevitable pain as a reason for not being able to “trust” the “natural process.” Several indicated that they, “had a low pain tolerance,” or was a “wimp” and compared the anticipated pain of childbirth to that of having had a broken bone.

A PSYCHINFO search for the words perception and fear and returned some 16000 hits, narrow by including the phrase “physical health” and still over 1000 hits (only included the years 2008-2011). It seems clear, and not worth debating, that fear and the perception of fear and intrinsically linked. And beyond this have implications on the physical body and health. Whether a danger (source of fear) is real or *just* our

perception (in our mind *only*), physiologically this does not matter – it is real because we believe it is real and our physical body responds the same. Physiological responses to fear: fight, flight, freeze, submit.

What the TV taught has women

In response to my inquiries about their experiences and perceptions of fear and its influence on their births – all reported fear as a factor (in some capacity) – I would follow up with a question about where they believe their fears might have stemmed from. Undeniably their quick and prominent response was TV and Movies or simply “media.” In addition to mention of the role of the media several went on to mention – in response to this specific line of inquiry or in other contexts of our conversations – the “horror” or “war” stories that they hear from other women. Perhaps I’ll refer to this as a social media!

The Rules

Whether it was mention of specific rules, like Dr. Reid, “here are my rules for a delivery. . .” or simply the acknowledgement that women made to their understanding of protocol and procedure there were significant indicators that “rules” are being applied to birth. I have to ask who the maker of these rules is and more so, what are the consequences when one opts to not follow said rules? Dr. Reid indicated, “If this lady doesn’t like my care she can go to someone else.” Ironically, Dr. Reid practices in a town with only one hospital, at which all physicians with privileges there must serve as on calls, so even if the woman decides to find a different care provider during pregnancy, during childbirth she still might have no option, but to be under his care.

As for the women’s understanding of the, all-to-likely unspoken, rules of birth most often the first one was, having a doctor followed by “go to the hospital” and finally mentions of “having tests” or “following procedures / protocols.”

“The rule is you follow the hospital policy over the individual”

Crazy & Other Judgments

There were several uses of the word “crazy” to describe having an unmedicated birth or giving birth at home. The women that did mention a desire to have an unmedicated birth indicated that they either heard from others or felt that others believed them to be crazy for this desire. Eleanor, who had two planned homebirths, indicated that she was also called crazy for her choice to birth at home.

Overwhelmingly women reported that the social climate surrounding the concept of medicated birth and/or homebirth was simply put – crazy! One woman made note of this social climate by stating, “The complete opposite of natural is regular, and natural is an alternative and really hippie-dippie. They look at you like you’re crazy.” In addition to mentions of craziness, there were other indications of feeling judged – socially – for the method of delivery or other birth experiences. “C-sections

are for celebrities who were too vain to have babies. That's what people think about women having c-sections."

Business

There was mention of the cost of certain procedures and the ways in which a hospital is a business. One woman indicated, "I imagine [cesarean's are] more money for the hospital...they stay longer, there are other people like the anesthesiologist...it's a business too." Dr. Reid reported he gets, "paid more for c-section, why in the world would we delivery somebody vaginally?" Jessica noted, "It's all about money, production, getting these women through, we need to know how to keep them on the line, we don't need them to know about normal birth...greed."

Health Reports

Women will report on their health outcomes during pregnancy, "uneventful pregnancy" or "I had gestational diabetes," etc. and then share their childbirth experiences. The conclusion of their tellings about pregnancy and birth rarely resulting in any account of their physical health – only babies health. "baby was fine. Small, 5 pounds. [baby's] Stomach fine." "The baby was healthy. Everything was okay." It seems this might be an example of the dominant notion that baby is the primary focus, as Dr. Reid suggested, or also an assumption that baby is in danger.

Power of Language – influencing perception

"As we started shifting health care into institutions we start talking like doctors and doctors are all about pathology. What went wrong here, we don't really care what went right, we never remember what went right, we remember what went wrong. So we medicalized it and that's the language we talk to people in and they hear it and then they talk to their friend..."

The Birth Blame Game

Doctors blame lawyers and women, women blame themselves.

Breastfeeding

2nd baby if breastfeed because I refused to pay for formula and I did not qualify for WIC. 1st baby was formula-fed because I had WIC and it did not even occur to me to breastfeed her

There seems to be some irony, worthy to note, in the fact that most women in this study indicated they either breastfed or desired to. Of these all felt it was what was "best" and what was most "natural" as reasons for breastfeeding. Several made statements about their bodies being "designed for" breastfeeding. I notice a contrast between the reported desires to, or understandings of, breastfeeding as nature's design, but only one woman (Eleanor) made comparable statements regarding philosophy, approach, or understanding regarding the body's design and ability to birth. Some women hinted at this, with comments like, "I know women have been doing it for thousands of years..." but would typically follow up such comments about their own body's ability, "I'm kind of wimpy."

Risk& Liability

There was mention of risk (whether briefly or at depth) in every single interview. The professional participants seemed to discuss this issue at greater depth and most specifically Dr. Reid spent a lot of time mentioning risks and talking about avoiding lawsuits. Women would mention being “high risk,” not want to “take that risk,” or risks not [being] “worth it.” In addition to mention and use of the words risk and liability, several women made mention of their understanding of a provider needing to “cover their butt,” – essentially a liability issue.

Susan indicated that she, “felt like [risks] were overemphasized...[doctors] have to do this because they are covering their butts and sadly so much of the medical community is now driven by liability and covering their butts but I just kinda went alright you have to do this.”

Eleanor discussed her experiences with the misconceptions about homebirth and stated, “there are 3 sets of people: ‘Oh that’s amazing,’ ‘Oh you’re crazy,’ and ‘Oh that’s great, but I could never do that , you’re really brave, I’m too high risk.” She went on and said that her, “[Midwife] takes high risk and makes them low risk through proper care, she believes most high risks actually aren’t.”

-Refined and Combined-

Not a fan of doctors, hate being in hospital, at the end of the day still peace-of-mind, still security of knowing I’m in good hands. They’ve been through enough training (Isabella)

Glad I was at the hospital, safe place for me to be...a little less of the medical would have been nice though....attacked, bombarded with when checked in...that scared me. Didn’t know what was happening...’well, your chart says’...(Jody)

Uneventful Pregnancy

Phrase repeated in nearly every, if not all, interviews – will have to double check for sure

Incentive

He wasn’t coming out, and she asked if I wanted episiotomy. I asked if it would hurt...one more push and his head was out

Dr. Reid also made actual mention of the word incentive more than once in our conversation. He spoke about the incentive to do cesarean’s, legal incentives, and what he perceives as women’s incentives for several things in life and childbirth.

Planning / Preparation for Baby

Going to CB classes: I wanted to know what was going to happen to me, wanted to know what to expect and what was normal.

How does woman feel about herself?

Some reports of regret and self-blame about decisions they made.

“I don’t feel like that, not a real mom because I didn’t push them out.”

Didn’t you hear me?

Doctor ‘oh, your placenta is really healthy,’ I’m too tired to argue at this point...didn’t you hear me

Vocalization, noise, and the notion of the good patient

Vocalizing a lot

Get the baby out

After 11 hours I wasn’t progressing the doctor said we could do a c-section...let’s go get her, why hurt if I didn’t have to (Judy)

Used a support belt to belly bind, acupuncture, chiropractic – discouraged, nothing seemed to work...I was desperate. It was a deadline that was stressing me out, really didn’t want an induction in the hospital

Oh my God, I need to get her out now, I couldn’t hold it, couldn’t stop it

Questioning Self

Am I going to be able to care for baby? (Jody)

Belief in body

You’ll know your body (jody)

I felt great, but I would never take that because I was always thinking what are the doctors thinking, what else haven’t they told me? (jody)

I knew my body could do it, but they kept pushing...tests...well my bodies telling me too, and if we could work together on that...I’ll take a back seat and let you do whatever you want to do (Jody)

Use of Pain Medication

Attitudes and perceptions about pain medication.

Asked for some kind of pain meds. As soon as I could have them, I’m sure natural is wonderful and all...I don’t see a need to put myself through that pain, if it hurts, then I’ll get medicine so it will hurt less.

I want to try, but I was open to epidural

APPENDIX L TALLY SHEET

Broad Categories

- | | |
|---|--|
| <p>①. Pregnancy as pathology (Perceptions)?
 </p> <p>②. Fears
 </p> <p>③. Power, Choice, Control, and
Informed Consent
 </p> <p>4. Passive and Active
Participation in Process </p> <p>5. "I guess I have no choice."
Then I was scared" #2/#3</p> <p>6. Informed Consent #3</p> <p>7. Every pregnancy is different,
but... Rules</p> <p>⑧. I'm a person, not a chart
 </p> <p>9. It takes a village #12
 </p> <p>10. Don't like hospitals </p> <p>11. Induction </p> <p>⑫. Real Conversations, Hearing

'it will be okay'</p> <p>13. Stress & Relaxation
#2?</p> | <p>14. Do whatever you want to
prevent a cesarean </p> <p>⑮. Do whatever you want to save
baby </p> <p>16. Doctors and Nurses
 </p> <p>17. Doctors and Midwives
 </p> <p>⑮. Perceptions of childbirth
Med/tech view = </p> <p>19. What the TV has told women
 </p> <p>20. The Rules </p> <p>21. Crazy & Other Judgments
 </p> <p>22. Business </p> <p>⑳. Health Reports </p> <p>24. Power of Language - influence
- perception #18</p> <p>25. The Birth Blame Game </p> <p>26. Breastfeeding </p> <p>⑳. Risk & Liability
 </p> |
|---|--|

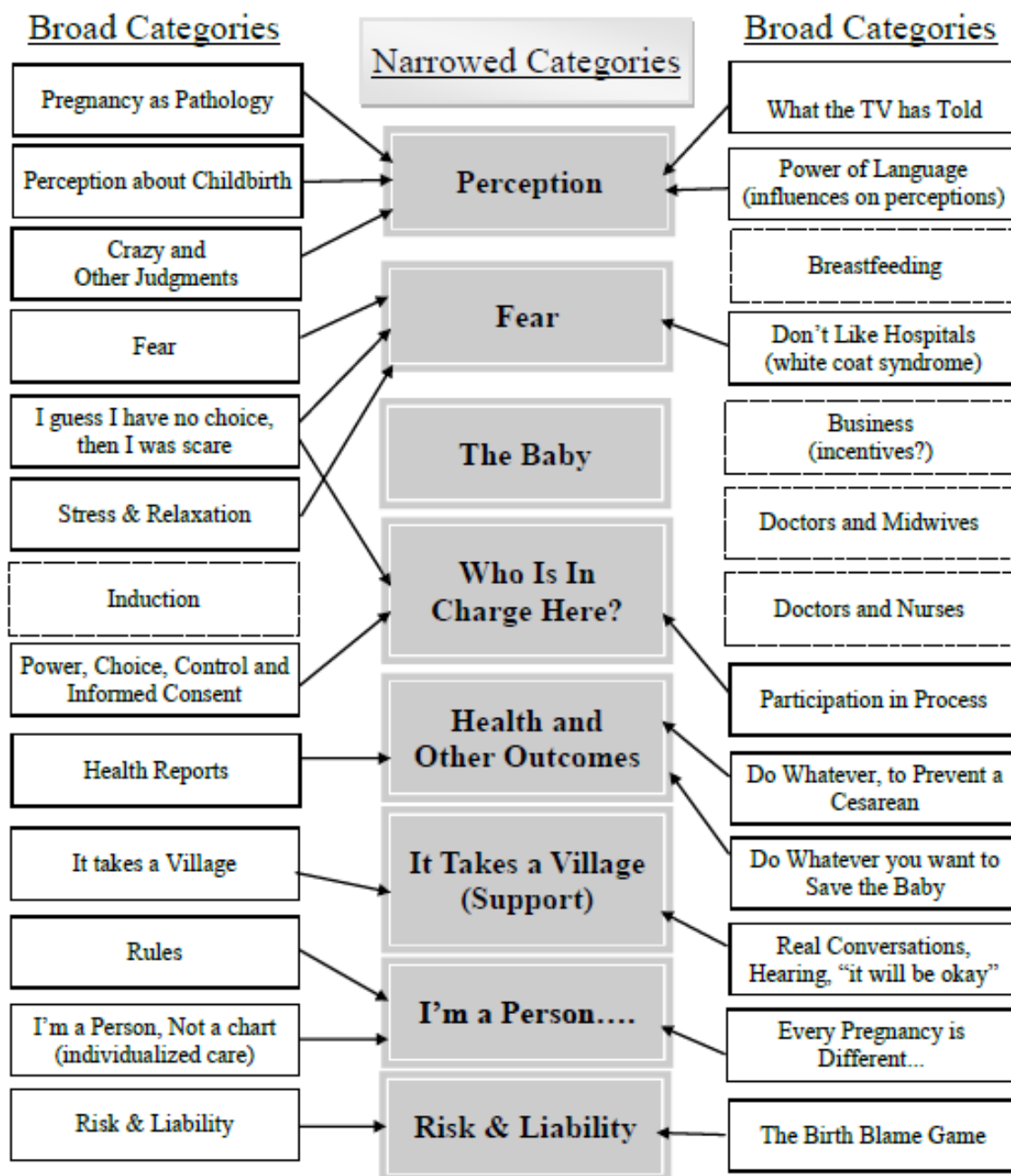
Baby?

Medical/technical view (pregas path)
* Seeking of dissemination of information
Sources of support (village)

Narrowed After Initial Development

1. Uneventful Pregnancy (Pathology) - med./tech view
2. Incentive
3. Planning / Preparation for Baby
4. How does woman feel about herself? #8/#9
5. Didn't you hear me?
6. Vocalization, noise, and the notion of the good patient
7. Get the baby out
8. Questioning Self #4/#9
9. Belief in body #8/#4
10. Reasons for the use of Pain Medication

APPENDIX M
TABLE REPRESENTING HOW CATEGORIES WERE COMBINED



APPENDIX N

PRELIMINARY RESULTS DOCUMENT

Preliminary results, presented in 8 categories

Prior to reading the following section it is important to be aware of the perspective that was used during analysis. This study is a feminist critique. What this means, in the simplest of terms, is that women's experiences are the focus. Beyond this, experiences in which marginalization or silencing of women's voices has, potentially, occurred are highlighted. This does not mean that your experiences, holistically or in part, were marginalizing or disenfranchising for you. Rather the the aim and focus of this study was to explore whether or not those elements were present in women's experiences and what this means for women. The critique element of this research simply means that within those highlighted areas as I may offer questions as to why this might be – I challenge the thinking (my own including) and the process of how we (Americans) do what we do.

Keep in mind that, with any study, you are only seeing a fraction of the data that has gone through several rounds of analysis and refining. It is a great challenge to try and report women's unique and extremely diverse experiences in a holistic-like manner. Therefore, what you are about to read is not everyone's experience and it is not the whole picture. It is a represented fraction of many unique and diverse experiences filtered through a feminist lens. What I intend to present here is not a unified image of women's pregnancy and childbirth experiences, but rather to shed light on some areas which are often not addressed, to open a dialogue, and to challenge our thinking and doing surrounding birth in America. The goal here is not necessarily agreement, but rather critically thinking about what I present. My sincerest hope, at the conclusion of this reading, is not that all readers will agree, but rather that all will find themselves with many more questions!

Category 1

I'm a Person, Not a Chart

There were an overwhelming number of statements and stories in which women described a desire, and hope, for individualized care. My understanding is that although women appreciate (and like) their providers knowing their names, they do not feel this is representative of receiving individual care. One woman described her interaction with different providers during her pregnancy and stated, "It was more of a person-to-person experience than a doctor-patient experience, which I appreciated." Another stated, "the [provider]'s very medical, and I understand [the doctor] has to look out for [him/herself]...they don't want a lawsuit, I get that, but at the same time if they know me as a person – not just medically – if you know me psychologically, spiritually, if you get the whole me you're going to understand me."

On the flipside there are the professionals who also indicated that individualized care is something they are not able to truly provide, but not for a lack of want to. Their inability to do so was cited as the result of two main reasons, 1) liability and 2) training.

Liability is one reason standard – not individual – procedures and routine – not individual – protocols are put in place in clinics and hospitals. They exist as a means to protect the providers and hospitals from lawsuits and are required by malpractice insurance.

This is not to say that these procedures and protocols are not potentially beneficial to the women as well, but simply to highlight that they are one reason by which women do not receive the individualized care they desire.

Training is the other frequently cited consideration when it comes to offering person-to-person care. Providers are trained to know procedures and protocols and to follow them. Several mentioned this as a frustrating and not representative of their desired way to practice. A 30-year labor and delivery nurse and childbirth educator summarized this issue with the statement, “the mother has to meet what is normal for the mass number of women not what’s normal for her anymore.” She went on to say, “nurses can’t look at individuals, every woman must fall into category...nurses don’t have the training to treat individuals. . . .The rule is you follow the hospital policy over the individual”

It would appear there is a significant rift between what women desire, and hope for, when seeking a provider and what is ultimately able to be offered. There is however, what appears to be an interesting irony when one examines this issue further, one worthy of our consideration. Women indicated, repeatedly, they wanted to be treated like a person, yet only one mentioned that she questioned her providers as to the reason and necessity behind a procedure she was asked to comply with. The other seven women all made note of various procedures they had to follow, and several indicated they even knew or believed that the procedure was likely unnecessary. Despite this, the seven indicated they complied because they felt that had no choice – compliance ultimately was a requirement.

Additionally, it is interesting that both women participants and professional indicated a belief in the uniqueness of each woman, each pregnancy, and each birth. Phrases like, “not every pregnancy is the same,” were common during interviews. Here again is an apparent agreement and understanding between women and providers about unique attributes, yet procedures and protocols remain standardized. So which is it? Are women, their pregnancies, and their births unique or standard?

Category 2

Risk & Liability

There was mention of risk (whether briefly or at depth) in every single interview conducted. The professional participants discussed this issue at greater depth than the women participants did. More specifically, the professionals discussed their fear of lawsuits and the means by which they practice medicine to avoid legal action. Women made statement like being “high risk,” not wanting to “take that risk,” or that a risk was not “worth it.” The frequent mention of this word also seems to support the concept, (discussed in more depth in category 6), that pregnancies (and childbirth) are perceived, and hence believed, to be a pathological condition.

Liability and risk are inherently (legally) interwoven, or at least it would appear so, therefore it was no surprise when participants discussed risks the idea of legal issues or liability was also frequently noted in their statements. Several women made mention of their understanding that a provider needed to “cover” themselves with use “disclaimers,” “waivers,” and “protocols” – oh my! These expressions were understood to mean efforts that providers engage in to decrease their liability. A common liability measure is the informed consent process (discussed in category 4).

A common example of women's experiences with risk and liability issues is represented in this statement: "I felt like risks were overemphasized, I know [doctors] have to do this because they are covering their butts and sadly so much of the medical community is now driven by liability and covering their butts but I just kinda went alright you have to do this, I get it."

Category 3

It Takes a Village

One provider spoke about the well-known African saying, "it takes a village to raise a child," and suggested that, in her experience, we no longer have a *village* (in concept or reality) in America. The ultimate consequences of this, specifically, of course, to women during their childbirth experiences were highlighted in the discussion. The village ideal seems connected to notions of both support and nurturing and the necessity for those during childbirth and parenting. Several other women mentioned that connecting with other positive and encouraging women was supportive and beneficial to them psychologically and spiritually as they approached their birth and parenting.

Not one participant referred to their childbirth experiences as negative. However, I still asked women what may have enhanced their experiences even more and/or reduced any of their fears. Feeling supported and encouraged was resoundingly the answer. Several women indicated that encouraging and positive conversations with other women prior to birth benefited them emotionally and spiritually. One woman specifically referred to a desire to have had a "real" conversation prior to her birth, which seems to indicate a significant deficit – or at the least a feeling a lack of genuineness in this area. Another discussed feeling a sense of comfort and encouragement from gathering with other women during her pregnancy in what she referred to as, "group therapy with other women." Several women specifically stated that they simply needed to hear phrases like, "it will be okay" and "you can do this."

Women seem to agree that support – perhaps a village – is something they would appreciate and benefit from during their tenure in the maternity (and parenting) culture.

Category 4

Who Is In Charge Here? Power, Control, and Informed Consent

The frequent use of phrases like, "they said," "they allowed," "they did..." in women's accounts of pregnancy and childbirth seems to have possible implications for power and control. With these notions of power and control issues of responsibility seem to be naturally embedded. For example, the person in the driver's seat (i.e. in control) is typically the one considered to be responsible for the behavior of the car. Certainly there are people who do not like to be in the driver's seat – this is true. Just as many women suggest they do not want to have control or be responsible for the process of birth. This is a fine and appropriate stance to have. However, the question that I have is, why? The answer typically seems to connect to the perception that birth, by default, is inherently risky or pathological and by having someone else – a trained expert – in the driver's seat, a safe outcome is more likely to be achieved. This philosophy and approach is apparent in women's statements like, "I don't know what I'm doing, [the doctors] the expert." Again, I simply question why it is that women think and feel this way – that they "don't know." The ultimate question I ask here is, do women actually have the choice to be in the driver's seat or not? In order for a

woman to be able to hand over the keys and chose the passer seat option, she had to have had the keys in the first place. Which experience (driver or passenger) makes the woman feel good, feel empowered? Ultimately only she can decide this, only she can say what that may be, but she can only do so if she truly had the option and choice within her control.

These ‘power phrases’ and the implications for control and choice issues are also inherently linked to the concept of informed consent. It was rare, in this research, to find a woman use an expressions like, “they asked me,” or “they offered me” and then follow those phases with a conversations that would indicate informed consent had occurred. Rather it was statements like, “they gave,” “they went in,” “they had to.” Some women stated specifically that they were not asked (about a consenting to a procedure or intervention), instead they were told what was about to happen to them and what to do and they did it – there was no choice in the matter or a formal consent process. However, as one professional participant said, not consenting is, *not* consenting; meaning lack of consent it not to be mistaken for actual consent.

One provider offered this challenge (adapted for this context) during our conversation about consent and choices: Think about it, right now, as you are reading this, think of a time you questioned your health care provider? Truly, questioned them – the reasons and motives behind recommendations. Have you ever done this? How did it feel? Were you comfortable in this role (challenger / inquisitor), why or why not? Not simply in a pregnancy or childbirth context, but in any medical context. When a doctor gives their recommendation (their expert opinion) what further questions do you have for them? Do you ask about alternatives, about risks of taking recommendation versus not taking it?

“By any means necessary to make it happen, so let’s not ask questions about the rest of the process,” was one participant’s statements regarding the matter of questions and consenting. Her statement reiterates the belief that we (Americans) should not question care providers. What was highlighted in the critical thinking challenge (above) was the notion that, in the experiences of that provider; it is likely that few people have ever (in contexts outside of childbirth) truly given informed consent. The provider suggested that American society, our culture, has taught us to behave in a certain, submissive, manner when interacting with medical professionals. This social construction, as it is known, is based on the inherent power-dynamics – the person with the knowledge (the expert) holds the power. This also relates to the idea of “the good patient,” and what women have experienced, and/or fear if they question their care provider. Several women indicated they were consciously aware of their behavior during birth and intentionally suppressed their impulses³⁹ (like making sound) to comply with the image of a good patient. Women also indicated an awareness or fear of being labeled in a negative manner by the medical care providers if they “complained” (questioned) instead of complied.

Category 5

Fear

A statement like, “He’s the doctor he knows, so I guess I have no choice. Then I was scared,” weave together the concepts of power, choice, and consent (category 4) with fear. Feeling a lack of choice or lack of control was frequently cited as influencing, and

³⁹Synonym: naturalness

increasing, fear. This makes sense considering that choice and control are psychological constructs. Many women remarked that pregnancy itself brings with it a feeling of one's own body not being hers anymore. Scholars have often used the word "vulnerable" to describe a woman's physical and psychological state during pregnancy and childbirth – and I would add early parenting. Therefore, making a connection between power and control issues and the perception of fear is not a great leap to make.

Every interview with the women participant confirmed that fear, at various levels and contexts, was present during pregnancies and births. Different sources or types of fears were reported, from being in the hospital to pushing the baby out to not knowing. The professional participants also all noted their own fear and confirmed the by their own observation that women experience fear and anxiety during their pregnancies and births. Professionals specifically indicated that their fear was primarily of lawsuits and that this fear significantly influenced how they carry out job duties and interacted with women consumers (i.e. patients).

Some women indicated specifically that they did not like being in the hospital. Being in the hospital or clinic setting increased their stress levels and anxiety. Other's mentioned a desire to discharge as soon as possible to be back in their home where they felt more "comfortable." One woman stated that when she got home from the hospital after the birth of her daughter she, "just bawled...there must have just been this weight that I was carrying, and once in confines of own my own house I could let it out." This final statement struck me as particularly poignant and again potentially representative of the idea of the "good patient," – a woman in *control* of her emotions, or at the least not expressing them publically. Additionally, this final statement, speaks to the idea of emotional safety and security. She implies that her home was a space (her turf, if you will) where she felt safe enough to express her emotions. This notion suggests that hospitals, perhaps by default, are less equipped to provide this emotional security.

Despite the fact that many women mentioned home as feeling better or more comfortable and a place of emotional safety it was the hospital that the women chose for their physical safety and the safety of the baby. However, one woman, who also indicated that the hospital made her nervous, said "it made more sense" for her to have her baby at home. At home she felt safe and comfortable and this reduced her fear and anxiety. It was her belief that her emotional state of being comfortable and relaxed would influence her physical state during childbirth. Several other women also made mention of "stress" and/or a need to "relax" during both their pregnancies and births. These women also noted a connection between their psychological relaxation and the progression of their labors. "When I finally did [relax] my body was able to labor and progress...instantly."

Category 6 **The Power of Perception**

Perception is a very powerful psychological construct. What perception presents us with is the notion that if we believe something to be real, then (for the believer) is it ultimately real. If I perceive that I am in danger my body reacts (physiologically) as though I truly am in danger. My heart will begin to race, my breathing may shorten, I'll begin to be hyper-alert and hyper-sensitive, I'll struggle to concentrate, and so on. Whether the danger (the source of fear) was real or *just* my perception (in my mind *only*), physiologically it does

not matter – it is real because I believed it to be, and my physical body responds the same. Take for example when someone accidentally startles you, the threat was not real, but your body still responded as though it were. The startle (stimulus) sent you mind into an automatic response mode – commonly known as fight or flight.

One indication of women's perceptions regarding pregnancy and childbirth was noted in the way they discussed their health (discussed in category 7). Women would often state that a pregnancy was "uneventful." Seeming to imply that, for whatever reason, women assume that some "event" (appearing to be medical) was anticipated as likely to occur. One woman also said, "My pregnancy was pretty uneventful, so I guess I'm really lucky in that way." Common first descriptor phrases like this seem to imply that women are defining (perceiving) their pregnancies and births in medicalized terms. No women in this project simply stated her pregnancy as "good," instead it was uneventful. This use of language certainly has implications worthy to reflect on in this perception conversation.

Another consistently reported perception was that women believed childbirth was going to be painful and this caused fear. One woman said, "It's going to hurt. Gonna hurt, hurt, hurt." Another stated that she, "really believed that it was going to hurt and be bad." Contrastingly, many women would also mention a belief in their bodies "natural" ability to give birth, because after all, "women have been doing it since the beginning of time." What was interesting about this was that they cited their own shortcoming (inability to endure the inevitable pain) as a reason for not being able to "trust" the "natural process." Several indicated that they, "had a low pain tolerance," or as one woman said, she was a "wimp" and compared the anticipated pain of childbirth to that of having had a broken bone. What I am trying to highlight here is the influence of language on perception. In truth, language could be considered even more powerful than perception itself, for language has a significant ability influence our realities. In a final irony regarding this matter of language and perception, a few women reported that in the end they found childbirth to be "not that bad."

In response to inquiries about their experiences and perceptions of fear and its influence on their births, I would follow up with a question about where they believe their fears might have stemmed from. Undeniably their quick and prominent response was TV and movies or simply "media." In addition to mention of the role of the media several went on to mention – in response to this specific line of inquiry or in other contexts of our conversations – the "horror" or "war" stories that they hear from other woman. Perhaps I'll refer to this as a social media!

Another common response to questions about sources of fear and childbirth perceptions were description of social influences and what others "say" and "tell" about birth – again, emphasizing the influence of language on perception. There were several uses of the word "crazy" to describe having an unmedicated birth or giving birth at home. The women that did mention a desire to have an unmedicated birth indicated that they either heard from others or felt that others believed them to be crazy for this desire and in fact found herself often discouraged (verbally), even by strangers, to not have an unmediated birth. One woman, who had two planned homebirths, indicated that she was also called crazy for her choice to birth at home. Overwhelmingly women reported that the social climate surrounding the concept of medicated birth and/or homebirth was simply put – crazy! One woman made note of this social climate by stating, "the complete opposite of natural is regular, and natural is an alternative and really hippie-dippie. They look at you like you're

crazy.” In addition to mentions of craziness, there were other indications of feeling judged – socially – for the method of delivery or other birth experiences. “C-sections are for celebrities who were too vain to have babies. That’s what people think about women having c-sections.”

Category 7 Health Reports

I started all of my conversations with women by asking them to “tell me your birth story” or some variation thereof. All the women began their birth stories by indicating a measure of health. Most would use the exact phrases, “healthy” or “uneventful” to describe their pregnancies. Their stories about their pregnancy and childbirth experiences were always preceded by health statements. This seems an appropriate representation of the way in which the medicalization of childbirth influences individual perceptions of the experiences. One provider stated, “What is making women focus on pathology⁴⁰? The medicalization of a normal process.” This provider went on to indicate, “[providers] don’t talk about or remember what went right, we talk about what went wrong. That’s the language medicalization brought. The women hear it and talk to their friends using it and so it goes...” In fact, I often had to prompt and probe for women to describe and share emotional experiences, but never for physical or health experiences. The birth stories I heard were quite often a telling of health and medicine, procedure and protocol, but rarely focused on their personal transformation and metamorphosis to motherhood. Ultimately, it seems appropriate to suggest that if the medical view has, potentially, influenced American women’s way of telling about their childbirth experiences, how too has it impacted the way in which they understand and internalize those same experiences.

Parallel to the way in which women reported their own health outcomes there was a clear focus on the health of the baby. In fact, statements from some seemed to imply women approached childbirth with an assumption that their child was in danger, by default of being born. Of course all agree the outcome of healthy baby is more than simply a desirable outcome – and I do not mean to imply anything less than this. However, I simply offer this here as another possible representation of the influence of history (medicalization) on our perceptions.

What I intend to suggest here is that it might be beneficial to consider one’s definition of health. Simply being alive – having breath and a heart-beat – is not the entire scope of health. The notion I aim to present is that of a holistic picture for both mother and baby. When this broader (holistic picture) of health is taken into consideration the entire experience and image of childbirth practices can be reframed and with this reframing comes a change in perception.

Category 8 The Baby, an “un-finding”

There were very few mentions of the baby’s role in the actual process of birth; not to mention the baby’s emotional (life-changing) experiences which occur on the occasion of their birth. However, the statements seemed worthy to note, if nothing less than for the sake of their rareness in the context of the conversations I had about birth. Additionally, I provide

⁴⁰ Medical condition or illness

these statements (quotes from participants) for the sake of our own further personal reflections as we consider the social construction of birth in America.

- Nobody ever told the baby that anything was going to happen...there was no post-it-note stuck to the womb saying today is the day (Discussing scheduled cesarean birth).
- There is a powerful voice that babies have, that we as a society have learned to ignore.
- The baby had a say in it, it's not all about me, it's about our journey together.
- We've got to have an open dialogue...breastfeeding, hormones, the baby. . .
- Separation of babies and moms following birth. . .
- [Baby] just made her debut; she wasn't going to wait for anything. [Baby] just delivered herself.
- It prepares the baby. . .

APPENDIX O

INSTRUCTIONS AND FEEDBACK FORM FOR REVIEWERS

Instructions for Reviewer

Thank you for your willingness to review the preliminary results of this study and offer your feedback. Your input and feedback is truly important to me and it will help me as I continue to refine and finalize the conclusions that I am making regarding women's experiences with pregnancy and childbirth in America. There are a couple of things which may be helpful for you to know before you read the results document.

Sample

The sample for the results that you will be reading included 8 women, all whom have given birth between 1997 and 2010 in America. Also 4 providers are represented; 1 obstetrician of nearly 20-years, 2 certified nurse midwives one practicing in the hospital and one practicing out-of-hospital, and 1 labor and delivery nurse for over 30-years. It is important to note the influence of historical trends in birth and recognize that as a result some of what you read may or may not resonate with you, depending on the historical context of your own experiences and knowledge about this subject.

Writing Style

As I indicated this document is still a draft and your feedback is one element I would appreciate to help in creating the final document. Please keep this in mind as you read, you may find typos, things may not be clear – feel free to point them out if and when you find them. Although this may be a draft, my goal in sharing is not for the sake of editing, but rather your feedback. I am having a hard time accepting that a polished document is not what is needed for the sake of review and sending this “as is.” The style of writing is primarily academic, as I am sure you anticipate. Direct quotes from conversations are used as well as summarization statements from conversations I had with participants. Also, be aware that this study is a feminist critique; therefore, embedded within the writing I often pose questions. These questions are intended to promote personal reflection and/or challenge dominant ways of knowing.

Feedback

The ultimate goal and purpose of conducting this review with you, participants and peers, is to ask for your further input and reflection on the conclusions I'm drawing. I will take your feedback, as much or as little as you would like to provide, and use the information as I re-evaluate and refine the categories I've created into themes. It is very important to me, and to the credibility of this research, that the results I report are representative of the participants experiences. This does not mean that I am seeking agreement from each participant – this would be an impossible task as each of you had very distinct experiences. Rather what I would like to know is that my categories resonate with you, do they make sense, do they seem familiar to you, am I on the right track? And if, in fact, you feel I am not on the “right” track I want and need to know about this.

Following your review of my preliminary results please complete the feedback form I've provided and email it back to me at ahardy@iastate.edu. If you need to contact me with any questions or concerns I can be reached on my cell at 515-231-1523.

Feedback Form

I have asked several different people to provide me with feedback, so it would be helpful if you would indicate your status as a reviewer of my preliminary results.

_____ Participant
_____ Male

_____ Non-Participant
_____ Female
Have you experienced childbirth?
_____ Yes _____ No

Please consider and respond to the following questions regarding the document you read:

1. What did I miss?

What do you think I may have left out or not emphasized enough?

2. What did I get wrong?

What pieces in the document do you disagree with, feel I over/under stated, what would you have said differently?

3. What did you connect with?

Did any pieces of information resonate with you? Please elaborate.

4. What do you feel you could not relate to?

Did any pieces of information not fit with your own understanding about birth or your personal experiences with birth? Please elaborate.

5. Please share anything else with me regarding the document you reviewed.

Thank you!

APPENDIX P
EMAIL TO PARTICIPANTS

From: ahardy@iastate.edu
To: [REDACTED]
Date: Fri, 4 Mar 2011 21:03:28 -0500
Subject: YOUR birth story

Hi [REDACTED],

Attached is my [re]telling of your birth story. Of course, it's brief, I'd like to write a whole book chapter for each woman's story, but I just don't have the space to do that for the dissertation. I'm sharing this with you for your review, as it is still YOUR story to tell. I want to be sure I got it "right" and did justice, with this abbreviated form, to your story and your experiences. It is very important to me that I honor your experiences.

So please review, edit (it's still pretty rough), and share your thoughts and comments with me. If you do want to make any changes, edits, and comments could you please use "track changes" in Microsoft Word? If you don't know how to do this I can tell you, it's easy - fear not.

Let me know what you think. Hope you're well.
~Mandi

Mandi Hardy, M.A., Ph.D. Candidate,
Human Development and Family Studies
Iowa State University
70 LeBaron Hall
515-231-1523 (cell)

APPENDIX Q SELECTED EXCERPTS

Email from participant Layla:

My oldest was born in Dec. 2006. At about 37.5 weeks I had a routine check-up and the OB accidentally broke my water (it can't be proven that's what happened, and I'm not trying to blame her, but I think it's pretty evident that was the case). Probably around 12 hours after my water broke; I was still not dilated at all and hadn't had a single contraction, so they gave me pitocin to induce labor. My labor was challenging - I went from nothing to full blown contractions, pretty close together in a matter of minutes (probably an hour or two after they gave me the pitocin, but I'll have to ask my husband to be sure - my memory of it is a little fuzzy), so I went ahead and took the epidural (I wanted to try it on my own first, but was open to an epidural). I think it was around 6 hours later...again, not positive anymore, that my son was born - healthy and ready to eat he was!

My second was born in Aug. 2008. This time I warned each OB at my later check-ups (which I think might have been a little annoying to them, but I wanted to make sure they were aware) that my uterus tends to be high and that my water broke immediately after/during a routine check-up with my first child. I carried my second to term. I woke up with minor contraction in the middle of the night. They were getting closer together so I went to the other room and did some more organizing (nesting I think) while I timed them. About 5:30am we took our son to our friends' house and headed for DM (where my OB is and where we were planning to deliver). I had some anxiety about not getting there in time, but not enough anxiety to make me change to an OB in Ames. Anyway, on our drive south I only had like one or two sets of contractions, so I thought they'd send us home. They thought they probably would too, but when the nurse checked me, I was dilated to 4 and was around 80% effaced (if I remember correctly). The admitted me and labor progressed. After a few hours, I was 100% effaced and dilated to 5. My water had not broken, so the OB came by and broke it. Shortly after that, labor progressed quickly. Again I said I wanted to try it on my own, but was not totally against an epidural. My labor and delivery nurse was WONDERFUL! She shared her experiences with me. She'd had an epidural with her first and went natural with her second. She said that I was doing great and that if I wanted to try, she really thought I could do it. My husband agreed. At that time, I think that's what I really needed to hear. Our baby was getting close to arriving and things got hard and I wanted the epidural, but it was too late. I pushed through and made it. After my son was born they had to clean out his nose, etc. (there was macomium (sp?) in my fluid) and then they handed him to me - it was wonderful. Afterwards my nurse asked me if I was glad I did it without the epidural. I told her that at that moment I wasn't sure, but to ask me later. Now I'm glad I did. It definitely wasn't easy, but was rather fast and I had a better idea of how I'd progressed because I could feel it. With the epidural, I was completely relying on my husband and my nurse to tell.

Participant: Molly

When I was induced, I just really didn't want that because I wanted to be able to do a drug free delivery and I was just afraid of what pitocin would be like and that I would not be able to have that [drug free delivery]. [OB] would not strip the membranes; she was concerned about introducing infection or something like that. [OB] said that [OB] did not do that, but what she did offer was to break my water and see if that would kick it in because I was already dilated and

effaced. I walked in at a four and maybe two thirds of the way effaced. So [OB] did that but it was going nowhere and by three o'clock when [OB] came in to check me again I was just sobbing, I'm not in enough pain; I know I need to be in more pain. Nothing more than the Braxton hicks that I'd been having anyway. So then it was kind of decided that I would have the pitocin and so I went from 3:00pm on a Friday and then at 10:30 things started to progress, I was having a really hard time managing the pain because I couldn't move around because I had to be on the monitor because of the stupid pitocin. I would sit on the ball and we couldn't get it to stay and it was just very, very frustrating and I was having a hard time, I fidget even when I have a headache, I'm a mover when I'm in pain so to not be able to move was really, I was really struggling and I sounded like a sailor on leave, I was just cursing and screaming, and I was terrible.

Participant Dr. Reid:

We are too quick to cut. And you know, we are sitting there in the doctor's lounge going you know I'm going to have to cut her, only not because the kids bad but I know I can't justify this strip in court for more than another 20 minutes. I can watch this. 8cm I know she's going to deliver in three hours, and I'm going to get a good baby out, I could probably stretch this one and get a good baby but I can no longer defend this monitor strip in court. And I'm at the point now that I have to cut her because I can't defend this. And the other guy will be sitting there looking at you going I would of cut her 15 minutes ago because your right you can't defend this anymore and if they want to get 9-9 APGARS, well you know you are supposed to get 9-9 APGARS, I could of pushed her father but I can't.

[Is that the 1% issue?] - Mandi

There is always somebody that will testify against you. You have got to start figuring out do I want to spend three years of my life defending what I've done today because it will take a year for them to file and it will take two years before it gets to court, I'll listen to all the lawyers argue back and forth, what I should have done, what I shouldn't have done. Do I want to drag my family through this, my wife? Or just do a section? You know it's not fair to her but it is fair for the rest of the system.

[And at that point, how does that conversation go with that patient. It sounds like you are saying, it's not necessarily an emergency. Do you feel like you have to kind of jump in and take over to protect yourself or do you feel like it's a real conversation that gets to happen with you and the woman, what are your options from your end? Are you able to really have that dialogue? The informed consent piece.] - Mandi

You can always get informed consent out of somebody (*puts arm behind back*); it's all in the way you present the data. I have talked people out of their body organs, trust me I can talk you into a section. You may not agree with me but are you going to stand up against me going, every bell and whistle in my system is screaming at me to cut you open, get the baby out before it's permanently maimed or dies. Now, you may not agree with me but that's what I'm looking for and I'm seeing your baby either permanently maimed which you will deal with for the next 50 years or they will die. What would you like me to do? It's a done deal. No one can stand up against that kind of pressure so you can twist people's arms to get whatever you want. It's just unfair to do it and we try our very best to be as fair as we can. And you know, I live with myself

for committing an injustice to her and giving her a good baby vs. can I live with myself for not doing it and putting my wife through this for the next three years sweating out a lawsuit. I do see my wife every day, I see the labor and delivery people every day, I get to see my nurse everyday and if this lady doesn't like my care then she can go to somebody else with the next baby. As much as I love my patients my attachment isn't as deep as it is to everybody else. I'm stuck.

APPENDIX R APPROVED HUMAN SUBJECTS DOCUMENTS

IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Institutional Review Board
Office for Responsible Research
Vice President for Research
1138 Pearson Hall
Ames, Iowa 50011-2207
515 294-4566
FAX 515 294-4267

Date: 12/3/2010

To: Amanda Hardy
2004 Melrose Ave
Ames, IA 50010

CC: Dr. Cathy Hockaday
1087 LeBaron
Dr. Sedahlia Jasper Crase
2327 Baker St

From: Office for Responsible Research

Title: The United State of Birth: A Feminist Critique

IRB Num: 09-485

Submission Type: Modification

Exemption Date: 12/3/2010

The project referenced above has undergone review by the Institutional Review Board (IRB) and has been declared exempt from the requirements of the human subject protections regulations as described in 45 CFR 46.101(b). The IRB determination of exemption means that:

- **You do not need to submit an application for annual continuing review.**
- **You must carry out the research as proposed in the IRB application**, including obtaining and documenting informed consent if you have stated in your application that you will do so or if required by the IRB.
- **Any modification of this research should be submitted to the IRB on a Continuing Review and/or Modification form, prior to making any changes**, to determine if the project still meets the federal criteria for exemption. If it is determined that exemption is no longer warranted, then an IRB proposal will need to be submitted and approved before proceeding with data collection.

Please be sure to **use only the approved study materials** in your research, including the **recruitment materials and informed consent documents that have the IRB approval stamp**.

Please note that you must submit all research involving human participants for review by the IRB. **Only the IRB may make the determination of exemption**, even if you conduct a study in the future that is exactly like this study.

IRB

For IRB Use Only	Modification Approval Date <u>December 3, 2010</u>	NOV 19 2010
	Continuing Review Approval Date _____	
	Approval Expiration Date: <u>1 yr - exempt</u>	

ISU HUMAN SUBJECTS CONTINUING REVIEW AND/OR MODIFICATION FORM

TYPE OF SUBMISSION: ☐ Continuing Review ☒ Modification ☐ Continuing Review and Modification

Principal Investigator: Amanda Hardy		Phone: 515-231-1523
Degree: M.A.	Correspondence Address: 2004 Melrose Ave Ames, IA 50010	
Department: HDFS	E-mail Address: ahardy@iastate.edu	
Project Title: Maternal Experience with Pregnancy, Childbirth, and Early Parenting <u>The United State of Birth: A Feminist Critique</u>		Date of Last Continuing Review: 04/08/10
IRB ID: 09-485		
Alternate Contact: Sedahlia Jasper Crase and Cathy Hockaday		Phone: 292-8842 (Crase) 294-7601 (Hockaday)
Correspondence Address: 2327 Baker St Ames, IA 50010 (Crase)		Email Address: sedahlia@iastate.edu
1087 LeBaron (Hockaday)		hockaday@iastate.edu
IF STUDENT PROJECT		
Name of Major Professor: Sedahlia J. Crase & Cathy Hockaday		Phone: alt contact info E-mail: see above alt contact
Department: HDFS		Campus Address: 1087 LeBaron (Hockaday)

FUNDING INFORMATION:

<input type="checkbox"/> External Grant/Contract	<input type="checkbox"/> Internal Support (no specific funding source) or Internal Grant (indicate name below)
Name of Funding Source:	OSPA Record ID on Gold Sheet:
<input type="checkbox"/> Part of Training, Center, Program Project Grant – Director:	Overall IRB ID No:
<input checked="" type="checkbox"/> Student Project—No funding or funding provided by student	

CONFLICT OF INTEREST

The proposed project or relationship with the sponsor requires the disclosure of significant financial interests that present an actual or potential conflict of interest for investigators involved with this project. By signing this form, all investigators certify that they have read and understand ISU's Conflict of Interest policy as addressed by the ISU Faculty Handbook (<http://www.provost.iastate.edu/faculty>) and made all disclosures required by it.)

Do you or any member of your research team have a conflict of interest? ☐ Yes ☒ No
If yes, has the appropriate disclosure form been completed? ☐ Yes ☒ No

ASSURANCE

I certify that the information provided in this application is complete and accurate and consistent with proposal(s) submitted to external funding agencies. I agree to provide proper surveillance of this project to insure that the rights and welfare of the human subjects are protected. I will report any adverse reactions to the IRB for review. I agree that modifications to the originally approved project will not take place without prior review and approval by the Institutional Review Board, and that all activities will be performed in accordance with state and federal regulations and the Iowa State University Federal Wide Assurance.

Amanda Hardy 11/16/10
Signature of Principal Investigator Date

Student Projects: Faculty signature indicates that this application has been reviewed and is recommended for IRB review.

Sedahlia Jasper Crase 11/17/10
Cathy Hockaday 11/17/10
Signature of Supervising Faculty Date

Kerry A. Agnibet December 3, 2010
IRB Approval Signature Date

For IRB Use Only	EXPEDITED per 45 CFR 46.110(b) _____, Category _____, Letter _____
	STUDY REMAINS EXEMPT per 45 CFR 46.101(b) <u>2</u>
	WAIVER of SIGNED CONSENT per 45 CFR 46.117(c) _____
	WAIVER of ELEMENTS of Consent per 45 CFR 46.116 _____
	VULNERABLE POPULATION per 45 CFR 46. _____

DIRECTIONS: Section I: Key Personnel must be completed for all applications. Please complete Section II if this is an application for Continuing Review. If this is an application for continuing review and you will be modifying your project, please complete all sections of the form. **If this application is only to request approval for a modification or change to your study, please complete Section I: Key Personnel and Section III: Proposed Modifications or Changes.** Please answer each question. If the question does not pertain to this study, please type not applicable (N/A).

SECTION I: KEY PERSONNEL

List all current members of the project personnel, including any additions and excluding any deletions as described in Section III. This information is intended to inform the committee of the training and background of the investigators and key personnel.

NAME & DEGREE(S)	POSITION AT ISU & ROLE ON PROJECT	TRAINING & DATE OF TRAINING
Amanda Hardy, M.A.	Doctoral Student Researcher	IRB #278309 (9/7/09)
Sedahlia Jasper Crase, Ph.D.	Co-Major Professor	IRB (9/19/00)
Cathy Hockaday, Ph.D.	Co-Major Professor	IRB (2/12/02) 12-2-02

If you don't know your training date, contact the Office for Responsible Research for assistance.

SECTION II: CONTINUING REVIEW

Part A: Enrollment Status

1. ☐ Yes ☐ No Is the research **permanently** closed to the enrollment of new participants?
2. ☐ Yes ☐ No Have **all** participants completed all research-related interventions?
3. ☐ Yes ☐ No Does research remain active only for long-term follow-up of participants?
4. ☐ Yes ☐ No Are the remaining research activities limited to data analysis? OR
5. ☐ Yes ☐ No Participant enrollment has not begun and no additional risks have been identified.

For definitions and guidance on how to determine enrollment, please see the document entitled **Enrollment and Accrual of Study Participants** on the [IRB website](#).

Number of Participants Approved for Enrollment by IRB:	
Total Number of Participants Enrolled in the Study to Date:	Males: Females:
Number of Screen Failures (participants who were screened and deemed ineligible) to date:	
Check if any enrolled participants are: <input type="checkbox"/> Minors (under 18). Age Range of Minors: _____ <input type="checkbox"/> Pregnant Women/Fetuses <input type="checkbox"/> Cognitively Impaired <input type="checkbox"/> Prisoners	Check below if this project involves: <input type="checkbox"/> Existing Data/Records <input type="checkbox"/> Secondary Analysis <input type="checkbox"/> Pathology/Diagnostic Specimens
List Below the Estimated Percent of the Total Enrolled That Are Minorities	
American Indians:	Alaskan Native:
Asian or Pacific Islander:	African American:
Black (Not of Hispanic Origin):	Hispanic:

1. ☐ Yes ☐ No Have any participants withdrawn or have you asked any participants to withdraw from the study?

List number for each and reason for withdrawal:

--

Part B: Protocol Summary – Please use the amount of space needed to adequately address the questions.

1. Please provide a concise summary of the purpose and main procedures of the study.

2. Please provide a summary of how the study is progressing (e.g., progress to date in terms of the overall study plan, success or problems encountered, reasons enrollment has not begun, etc.)

3. Is there any new information (positive or negative) from this study (e.g., interim analysis) or elsewhere (e.g., current literature) that might affect someone's willingness to enroll or continue in the study? It is especially important for the investigator to notify the IRB of literature or information that's relevant to the risks to participants in the study.

4. Please provide a summary of amendments or modifications since last IRB review.

Part C: Adverse Events and Unforeseen Problems

1. ☐ Yes ☐ No Have there been any adverse events or unanticipated problems involving risks to participants or other people?

If yes, please describe the event(s).

If yes, was it reported to the IRB? Date reported

If report was not submitted, please explain why.

2. ☐ Yes ☐ No Have there been any participant complaints?

If yes, please describe.

Attach any reports submitted to NIH or a Data and Safety Monitoring Board. ☐ Attached ☐ N/A

Part D: Informed Consent

1. ☐ Yes ☐ No If a signed Informed Consent Form was required, was Informed Consent obtained from all participants?

If no, please explain.

2. ☐ Yes ☐ No Are all signed Informed Consent Forms on file with the PI?

If no, please explain.

- 3.
- ☐ Attached Submit a copy of the currently approved Informed Consent Document or informational letter and an original unstamped copy so a current IRB approval stamp can be added. If changes have been made, please submit the original, a copy with the changes highlighted, and a copy to be stamped with IRB approval.
- ☐ N/A
-
- ☐ Attached Submit an unstamped copy of all survey instruments, interview questions, recruitment materials, instructions, and all other material participants will see or hear during their participation so that a current IRB approval stamp can be added. Any changes to materials should be described in Section III. Please also submit the original, a copy with the changes highlighted, and a copy to be stamped with IRB approval.
- ☐ N/A

SECTION III: PROPOSED MODIFICATIONS OR CHANGES

If this application is to request approval for modification or changes to your project, please complete Section I: Key Personnel and Section III.

The submission of a modification form is required whenever any changes are made to an approved project. This includes, but is not limited to, a title change, changes in investigators, resubmission of a grant proposal involving changes to the original proposal, changes in the funding source, changes to data collection materials and informed consent documents, advertisements, confidentiality measures, inclusion/exclusion criteria, reports from a data safety and monitoring board, addition of a test instrument, etc. **NOTE: All changes must be submitted and approved by the IRB prior to their implementation unless the change is necessary to protect the safety of participants.**

1. ☐ Yes ☒ No Does your project now require approval from another institution?

If yes, please attach letters of approval.

2. The following modification(s) are being made (check all that apply):

- ☐ Change in protocol/procedures.
☐ Change in type or total number of participants. New anticipated total:
☐ Change in informed consent document.
☐ Change in co-investigator(s). New co-PI name:

Signature of new Co-PI: _____

- ☐ Change in funding source/sponsor. **If federally funded**, please attach copy of grant proposal.
☒ Other (e.g., change in project title, adding new materials, adding advertisement, etc.)

- ☐ Personnel/staff changes since the last IRB approval was granted? Please complete the following table as appropriate. **NOTE:** If the change involves a new Principal Investigator, a new Human Subjects Review form must be submitted.

Add	Delete	Last Name	First Name

3. Describe the modification(s) indicated above in sufficient detail for evaluation independent of any other documents. Be sure to describe all changes in detail and provide a rationale for the changes. When submitting revised documents please submit one clean copy of the new document and a copy with the changes highlighted.

Change of title: from "Maternal Experiences with Pregnancy, Childbirth, and Early Parenting" to "The United State of Birth: A Feminist Critique"

Adding research summary: This document will be provided to potential participants when they contact the PI requesting further information about the study.

Adding professional recruitment letter: To be sent (via postal mail or email) to various businesses, who provide services to women during the maternity period, to request participation in the study.

ISU IRB # 1	09-485
EXEMPT DATE:	3 December 2010

Iowa State University

Title of Project: The United State of Birth: A Feminist Critique

Investigators: Amanda Hardy, MA

INFORMED CONSENT

This is a research study. Please take your time in deciding if you would like to participate. Please feel free to ask questions at any time.

INTRODUCTION

The purpose of this study is to explore the attitudes and perceptions of women regarding their pregnancy and childbirth experiences and their early parenting practices. You are being invited to participate in this project because you have given birth and are not currently pregnant or because you offer medical care or other support to women during this period in their lives.

DESCRIPTION OF PROCEDURES

If you agree to participate in this project, your participation will take place in the form of a face to face interview, lasting approximately 1 hour, during the next calendar year (4/2010 – 4/2011). Although only one interview is necessary for your participation, often with a topic such as this it is beneficial to gain a deeper understanding through follow up conversations. These conversations may take the form of brief phone calls (approximately 15 minutes), email communication, or meeting face to face. Following our first interview we can discuss the option of continued participation and you can indicate your desired level of involvement. Regardless of what you indicate during this first interview, please note that you may change your decision at any time and that I will not make contact with you more than 3 times over a one month period, to request further engagement in the project. If the 3 contacts go unanswered I will not contact you again regarding participation in the project. When a request to meet for further conversation is made scheduling the meeting will always be at a time and location of your convenience and comfort.

During the project, you may expect the following project procedures to be followed: you will be asked to share your thoughts (perceptions, attitudes, beliefs, and experiences) about your pregnancy and childbirth experiences, as well as early parenting. This will occur during conversations at a location and time convenient for you. This researcher is seeking a collaborative relationship with you as a participant; therefore, the number of time we engage in these conversations will vary based on your desired level of involvement with the research.

RISKS

Risks of participation in this project are interpreted to be minimal; however, it should be noted that the discussions at times may be challenging emotionally and deeply personal. Although causing any emotional duress is not anticipated or intended, the occurrence of such is a possibility. In the case that you experience severe emotional duress, the researcher can offer you information for seeking appropriate counseling support to work through to address your feelings.

BENEFITS

No direct benefits are reasonably expected for any reason for participating in this project. Possible society benefits may include implications for counseling, education, and intervention concerning pregnancy, childbirth, and parenting. Additionally, the results of this project may be published.

COSTS AND COMPENSATION

You will not have any costs from participating in this project. You will not be compensated for participating in this project.

PARTICIPANT RIGHTS

Your participation in this project is completely voluntary and you may refuse to participate or leave the project at any time. If you decide to not participate in the project or leave the project early, it will not result in any penalty or loss of benefits to which you are otherwise entitled.

CONFIDENTIALITY

Records identifying participants will be kept confidential to the extent permitted by applicable laws and regulations and will not be made publicly available. However, federal government regulatory agencies, auditing departments of Iowa State University, and the Institutional Review Board (a committee that reviews and approves human subject research studies) may inspect and/or copy your records for quality assurance and data analysis. These records may contain private information.

To ensure confidentiality to the extent permitted by law, the following measures will be taken: identifying information will be kept in a locked cabinet or password-protected computer. All identifying information will be destroyed once the project is complete and the IRB file is closed, not to exceed a five year period. If the results are published, your identity will remain confidential.

QUESTIONS OR PROBLEMS

You are encouraged to ask questions at any time during this project.

- For further information about the project contact: Amanda Hardy, 515-231-1523, ahardy@iastate.edu, Sedahlia Jasper Crase at sedahlia@iastate.edu or 515-292-8842, or Cathy Hockaday at hockaday@iastate.edu or 515-294-7601.
- If you have any questions about the rights of research subjects or research-related injury, please contact the IRB Administrator, (515) 294-4566, IRB@iastate.edu, or Director, (515) 294-3115, Office for Responsible Research, Iowa State University, Ames, Iowa 50011.

ISU IRB # 1	09-485
EXEMPT DATE:	3 December 2010

PARTICIPANT SIGNATURE

Your signature indicates that you voluntarily agree to participate in this project, that the project has been explained to you, that you have been given the time to read the document and that your questions have been satisfactorily answered. You will receive a copy of the written informed consent prior to your participation in the project.

Participant's Name (printed) _____

(Participant's Signature)

(Date)

INVESTIGATOR STATEMENT

I certify that the participant has been given adequate time to read and learn about the project and all of their questions have been answered. It is my opinion that the participant understands the purpose, risks, benefits and the procedures that will be followed in this project and has voluntarily agreed to participate.

(Signature of Person Obtaining Informed Consent)

(Date)